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Abstract

Black communities are greatly affected by barriers that negatively impact their mental health. One of the significant barriers is that of stigma. Leaders of Black churches are in a position to shift the narrative. Black women church leaders, specifically, are uniquely positioned to provide a more progressive perspective and style of leadership to encourage the destigmatization of mental health. From the standpoint of Black Feminist Theory and sensemaking, this dissertation assesses Black women religious leaders' current role in discourse normalization surrounding Black mental health through sensebreaking. A series of in-depth interviews were conducted to capture the perception, personal experiences, and sensegiving messages Black women religious leaders shared around mental health. Findings indicated that Black women religious leaders combat the norm of stigmatized messages shared by communicating sensebreaking messages to promote the importance of mental health with their congregants and community members.

Chapter 1: Introduction

Despite the Black community making up only 13.4 percent of the U.S., Black people have the lowest life expectancy rate, highest infant mortality rate, a high percentage of preterm births, high percentage of C-sections, second highest in child obesity, most likely to have hypertension, second highest percentage without health insurance, the highest percentage living below the poverty level, and much more (Census Bureau, 2019; US National Center of Health Statistics, 2015). When it comes to health outcomes related directly to mental health, Black people have the highest national percentage of illicit drug use; often receive poorer quality of care; are less likely to be offered evidence-based medication or psychotherapy; are more frequently diagnosed with a major mental illness (i.e., schizophrenia); are more frequently misdiagnosed; are most likely to be incarcerated with mental health conditions; and are less commonly included in research (American Psychiatric Association, 2017). These outcomes have led to further barriers that discourage members of the Black community from seeking the assistance needed to manage their mental health, such as stigma, distrust of health care and researchers, lack of racially representative health providers, lack of culturally competent providers, and lack of resources (American Psychiatric Association, 2017; Conner et al., 2010; Murry et al., 2011). It is evident that the Black community is greatly affected by health disparities.

Research has focused on addressing these disparities and changing health outcomes for the Black community. However, much of the research in this area has addressed factors after such disparities have occurred. While this line of scholarship is imperative, it is a reactive approach. Public health scholars must also focus on preventive interventions and

more proactive measures (Zoller, 2010). Preventive interventions allow us to change social, environmental, and economic disadvantages at a systematic level, eventually minimizing the likelihood that such disparities will occur. If we only work reactively, we are merely placing a band-aid on the wound rather than addressing the cause of the wound. To achieve effective preventative interventions, we must gain a culturally competent perspective to develop a deep understanding of the community and pinpoint the best ways to help minimize health disparities. According to Dutta (2007), health scholars must place cultural members' perspectives at the center of research to reduce health disparities. To decrease the gap in health disparities, we must increase knowledge, awareness, and disseminate accurate health information to the community, which will allow the community to be proactive in dealing with health concerns and breaking down barriers. The information disseminated must culturally fit the community specifically (Dutta et al., 2019). Thus, the information must come from a trusted source within the community to be culturally fit. Some of the most culturally trusted people within the Black community are religious leaders.

Historically, Black churches have served as a safe place for Black community members to discuss emotionally laden and often traumatic life experiences (Cooper & Mitra, 2018). Black churches were considered the epicenter of the Black community. They were not only a place of worship; Black churches served many purposes, such as providing a sense of community, support, strength, professional training, life guidance, and leadership (Porter, 2018; King & Roeser, 2009). Leaders of Black churches were the go-to for guidance on decision-making (Porter, 2018; King, 2009). Thus, as a central organization within the Black community, Black churches hold great power in discourse

normalization regarding actions that are deemed appropriate and inappropriate within the community, especially surrounding health issues. Zoller (2010) argues [other] organizations that influence political, social, and economic power and access should also be considered public health organizations. Thus, health scholars should view Black churches as public health organizations and utilize their connection to the Black community to improve health concerns and decrease the gap in disparities (King, 2009; Thompson, 1963; Hays, 2015).

As one of the most influential organizations, the Black community often looks toward religious leaders for guidance as these leaders provide information and validation for their experiences and decisions (Porter, 2018; King, 2009). As the dissemination of information is central to Black churches' influence, more research should be conducted to understand the communicative nature of Black churches and their leaders. Some communication scholars have investigated communication in the church (Horan & Raposo, 2013, 2015; Porter, 2018; Jablonski, 1988, Byrd, 1986); however, such research is uncommon, and research on communication within Black churches is even rarer. Focusing on the communicative practices of leaders within Black churches while considering them public health organizations will provide a culturally-centered understanding of the relational nature of leaders and congregational members, the influential nature of the information that is being spread regarding Black health, and the role of Black church leaders in the perception of Black health. A deeper understanding of these factors will ultimately allow health scholars to minimize the gap in disparities based on the community's needs.

The limited research that has examined leadership with Black churches has mainly focused on men's perceptions (Silk, 2002; Hardy, 2012). Less studied is how Black women both influence and are influenced by leadership within the church. Women's voices have historically been suppressed within Black churches, leading to Black women being denied formal leadership positions (Loewen, 2016; Taylor, 2019). Yet, research supports that Black women are pursuing and attaining more leadership roles (Parker-McCullough, 2020). Although this shift is occurring, Black women's perspective as leaders within Black churches has not been as thoroughly captured. It is imperative for researchers to capture the experiences and perspectives of intersectionally marginalized communities as they occupy an "outsider within perspective" (Collins, 1998; Parker, 2001). Such perspective allows such communities to provide a more accurate and complete view of social reality (Harding, 1987). Thus, Black women's standpoints are vital to this area as they can provide a different level of understanding regarding leadership, what it means to be a leader, and how they enact leadership.

As much as health scholars can benefit from collaborating with their leaders, Black churches are also in a position to benefit from a collaboration with health researchers to reach the needs of their community members. While Black churches are still central to the Black community, research has shown that Black young adults are disengaging due to the leaders' outdated, conservative, and stigma-driven practices within Black churches (Cooper & Mitra, 2018). Hence, a disconnect exists between the historical teachings and practices in Black churches and the personal beliefs of Black youth, more specifically regarding mental health issues. Regardless of this shift to religious disengagement, Black churches are still the foundation of lived experience for Black people. Further, in times of turmoil,

Black people still turn to religious practices and teachings for guidance and support (Thomas, 2017; Pew Research Center, 2018). Therefore, there is still a need for Black churches to continue to play their role; however, they must take the necessary steps to remain ecologically fit for the Black community. Thus, while health scholars need to collaborate with Black church leaders, Black church leaders also need to work with health scholars to increase their knowledge and awareness of more progressive forms of leadership. Responsibility is now placed on Black churches and their leaders to understand how Black youth make sense of life experiences today so that Black church leaders can adapt their messages and practices accordingly. As leadership within Black churches has been rather homogenous and male-dominated, Black women leaders can provide this need shift in perspective and leadership.

It is crucial that when organizations work to progress their practices, the leaders of those organizations are at the forefront of that change as followers typically follow the direction of their leader(s). Therefore, health scholars should look to connect with leaders within Black churches, more specifically Black pastors and ministers, as they hold the ultimate leader role and "command significant influence within the community" (Corbie-Smith et al., 2010, p. 10). While studies support that Black churches have collaborated with mental health services (Taylor et al., 2000; Corbie-Smith et al., 2010), more recent studies show that Black church leaders lack the proper knowledge and resources to assist their clergy with mental health issues (Melody, 2019; Porter, 2018). Further, studies also show that stigma surrounding mental health within the Black church still exists (Neely-Fairbanks et al., 2018; Janee, 2013; Porter, 2018). Although often unintended, these factors can further stigmatize mental illness in the Black community, widening the disparities gap

by discouraging Black people from seeking more formal assistance. Therefore, leaders of Black churches must become more competent regarding mental health issues and more open-minded to determine when current mental health practices should be adapted to adopt more progressive forms of healing. Differences in leadership can benefit organizations as [marginalized] leaders can be more open to change, more representative, and provide different ways of solving problems (Eagly & Chin, 2010; Page, 2007). Thus, Black women leaders can provide the needed change and connection to the broader community within Black churches regarding mental health and wellness. Therefore, a research program should be developed to understand the role of Black women leaders in shaping mental health practices within Black churches.

While previous studies have assessed mental health within Black churches from the perspectives of church leaders, a majority of participants have been men. Further, nearly all of these studies have been focused on perception. However, perception is shaped by communication. To alter perceptions surrounding the stigma of mental health within the Black church, we must understand how church leaders make sense of mental health themselves and identify the messages they share with their congregations. Thus, the purpose of this dissertation is to identify and examine how Black Women church leaders make sense of their personal experiences with mental health and how that influences what they say to their congregations about mental health.

Chapter 2: Review of Literature

Black people take pride in their strength. As shown throughout history, strength represents a combination of this community's tenacity, determination, and perseverance. Black people have persevered through slavery, Jim crow, and police brutality, to name a few. Although great strides have been made to work toward equality, discrimination and racism still exist and significantly affect the Black community, more specifically their health. For instance, as the COVID-19 virus spread, statistics showed that Black people were disproportionately affected. According to the CDC (2021), racial and ethnic minority groups experience these health disparities regarding COVID-19 due to social factors such as discrimination, lack of healthcare access and use, as well as economic, educational, housing, and occupational inequalities. Out of all the racial and ethnic minority groups, Blacks were disproportionately infected at higher rates and were more likely to perish due to COVID-19 (CDC, 2021; APM Research Lab, 2021).

While many people experience economic, educational, housing, and occupational disparities, regardless of race or ethnicity, Black communities experience additional inequalities due to racism. Moreover, the inequalities mentioned above stem from historical discrimination and racism against Black communities. For example, statistics show that Blacks are twice as likely to be unemployed as their white counterparts even when they account for their education level (Economic Policy Institute, 2019). This employment gap has existed for decades (Pew Research Center, 2013). While there is no consensus on the causes of the gap, the gap has existed since abolishing slavery. Thus, it is evident that such disparities are systematically rooted and more difficult to dispel for Black people.

Members of the Black community are at a greater risk of experiencing adverse health outcomes, as shown above, due to systematic disparities. These unfavorable health outcomes are not limited to the physical. Mental health outcomes are greatly affected by inequalities as well. Some of the unfavorable physical health outcomes are a result of adverse mental health status. For example, studies show that Black women are at a higher risk of obesity due to their eating habits (CDC, 2018). Studies also show that Black women often overeat as a coping mechanism to stress (Connolly, 2011). Thus, if Black women were provided the proper resources to manage their stress levels, their likelihood of obesity and consequential health outcomes could be decreased, working toward a more equitable health level. Yet, healthcare and pharmaceutical companies try to address the issue after it has occurred with repeated drug prescriptions and doctor visits. Research also shows that Black women are less likely to utilize health care due to fear of being judged based on negative stereotypes (Abdou & Fingerhut, 2014). Such experiences can be minimized if we address the root issue of the problem proactively rather than reactively (Zoller, 2010) in a culturally centered way. It is imperative that health scholars further investigate ways to decrease health disparities before the health issues occur. One of the ways that health scholars can address such inequalities is by working to equip Black communities with the proper resources to manage their mental health. To address such concerns, we must first understand the cultural experiences and perceptions of mental health and illness within the Black community.

Mental Health and the Black Community

While many factors influence one's mental health status, research supports that race and racial discrimination are essential factors in understanding mental health within Black

communities (Williams, 2018; Porter, 2018; Conner et al., 2010; Fischer & Shaw, 1999). Race and racial discrimination impact mental health within Black communities in three main ways. First, racism directly affects the mental health of Black people when they experience the effects of it first-hand. For example, Black people often experience racial battle fatigue. Racial battle fatigue is mental, emotional, and physical suffering due to the constant battling of race-based discrimination. According to Smith, Yosso, and Solorzano (2011), racial battle fatigue leads to symptoms such as high blood pressure, constant anxiety, mood swings, headaches, increased sickness, and many other adverse health effects. Second, racism indirectly affects mental health as racial discrimination is often positively related to other societal disparities such as economic, educational, and political inequalities and lack of representation and support, as shown in the previous section (Economic Policy Institute, 2019; Bailey et al., 2017). Lastly, race and racial discrimination impact help-seeking behaviors within Black communities (Snowden, 2001; Avent, 2013; Porter, 2018).

All three of these impactful factors are interrelated and must be addressed to comprehensively improve the lives of Black people and decrease health disparities. There is an extensive line of research tending to the first two factors. Recent studies acknowledge the impact of race and racism on mental help-seeking behaviors and healthcare access and use within Black communities. However, future studies should begin to assess practical ways to reduce health disparities within the Black community. Thus, in a general sense, this dissertation aims to increase knowledge regarding the latter factor as understanding cultural preferences and perspectives of Black community members can better equip community leaders and healthcare professionals in decreasing health disparities. The

following sections will provide a review of *barriers contributing to mental health disparities within the Black community.*

Barriers to Help-Seeking

Research shows that Black people seek professional counseling and therapy at lower rates due to various barriers to care (APA, 2017). These barriers often discourage Black people from considering professional care as an option to addressing mental health issues. Health professionals and activists must identify and understand the barriers as it is the first step in dismantling and shifting the narrative. Such barriers include lack of access, mistrust of traditional service professionals and researchers, and stigmatization. This section will review these main barriers impacting help-seeking behaviors of the Black community.

Lack of Access. Black communities are at high risk of having little to no access to mental health treatment. Wells et al. (2001) found that African Americans were more likely to be uninsured or covered by Medicaid. Uninsured people have no available access to health care services. On the other hand, Medicaid is a government assistance program to help "people gain access to health care services that may not be affordable without Medicaid" (Medicaid, n.d., para. 1). While Medicaid is a form of insurance, it represents underserved populations and serves as a program to minimize disparities. According to the KFF (2019), 21% of the population is covered by Medicaid, and 33% of the population covered is Black. While Black people only make up 13.4% of the population (Census Bureau, 2019), they account for over a third of the population covered by Medicaid and in need of health care assistance due to disparities. Thus, a significant number of Black people experience disparities that affect their access to adequate healthcare.

Many Black families are unable to seek treatment due to the effects of financial strain. Some families may not be able to afford adequate treatment, while others may be unable to physically travel to mental health or counseling facilities physically (Murry et al., 2011; Chow et al., 2003; Ward, 2009). While Medicaid offers health care assistance, it does not always offset the entire cost of medical expenses or account for travel expenses. Regarding physical distance, many Black families live in urban or rural areas that are far from or do not have professional mental health facilities. Additional evidence shows that Black families who live in these urban areas are most affected by mental health issues. For instance, Busch and Barry (2007) found that mental illnesses such as depression, ADD, anxiety, among others, are shown to be most prevalent among children who reside in rural areas. In another study, Ialongo et al. (2004) found that major depressive disorder was most prevalent among young Black people who lived in urban areas. Further, they found that only 10% of those who were identified as experiencing or have experienced major depressive disorder ever received professional treatment. Ultimately, families who live in these areas lack adequate health care as they believe that quality mental health services are only available in big cities and cannot access such resources (Murry et al., 2011).

Mistrust of Traditional Mental Health Services. Another critical factor that affects disparities for the Black community is the mistrust of traditional mental service professionals. Some Black community members believe that only white professionals are available, and they are unable to truly understand Black people's experiences and thus, are unable to help. In Murry et al.'s (2011) study on perceptions about mental health care and help-seeking among rural African American families of adolescents, some mothers preferred not to send their children to formal support services because they were concerned

that white professionals would not understand their problems or necessarily care. In addition to the perception of the lack of understanding, community members are apprehensive regarding the motives behind formal assistance in health-related issues. Some Black people believe that mental health professionals do not care about helping Black people improve their mental health. Instead, mental health professionals prescribe medicine without properly assessing one's mental state or trying less invasive forms of treatment such as counseling (Conner et al., 2010).

Other members of the Black community are apprehensive about trusting formal methods of treatment due to the history of unethical research studies in the medical field on Black people. Bates and Harris (2004) conducted a study aimed to examine whether members of the public would recall the Tuskegee Study of Untreated Syphilis (TSUS) and whether their participants used the study to interpret biomedical research. Their findings indicated that only groups that were composed of African-American participants mentioned TSUS; and that while African American participants weighed their personal values in their overall decision to participate in medical research or seek assistance, TSUS made the African American participants suspicious of biomedical research. Historically racist studies such as the Tuskegee experiment cause apprehension within the Black community regarding trusting medical professionals, more specifically white medical professionals who make up a majority of the medical field. Therefore, events such as these lead Black people to be more hesitant in receiving help.

Stigma. One of the most prominent barriers to seeking mental health services is stigmatization regarding mental health, both outside and within Black communities. Stigma is the view of disgrace of a particular circumstance or phenomenon. Mental health

stigma is prevalent within the Black community as it is seen as a sign of weakness and reinforced as a private matter. Culturally, Black people are expected to be strong and resilient (Samuel, 2019). Conner et al. (2010) found that their participants would experience stereotyping and discrimination within the Black community. People would see someone as “crazy,” and this stigmatization led many people to hide their mental illness. There was a lack of support from people within the actual community to seek help. This also led to members of the Black community denying that they had an illness. The same study found that some members of the community suppressed their emotions so much that they were in denial that they may be depressed. The participants stated how they would stay busy to the point that they did not have any available time to think about their mental illness. Therefore, it was easier for them to forget about it (Conner et al., 2010). In Murry et al.’s (2011) study on the families of adolescents, they found that mothers were afraid to take their children to seek help due to being judged by their community. Mothers thought that people would blame them (the parents) for their children’s behavior. Mental health issues are highly stigmatized within the community, but stereotypes created and reinforced outside of the community further strengthen the stigma.

Although it is implicit, studies show that the media reinforces the stigma surrounding mental health and the Black community. One implicit reinforcement of stigma is a lack of representation surrounding Black people and mental health assistance. Participants reported that they only saw whites on mental health advertisements, which communicated that mental health services were for white people and discouraged Black people from seeking assistance (Conner et al., 2010). Ultimately, treatment was considered a last resort. If a Black person was seen seeking help for their mental health, they were

seen as weak. It was implied that people from the Black community were so resilient due to the history of racism that they were expected to deal with mental issues on their own (Conner et al., 2010).

To summarize, as a result of these barriers, many members of the community are left to deal with mental issues without professional help, often through unhealthy behaviors, suppression, or more informal forms of assistance (Jackson et al., 2010). Ultimately, when such issues do arise, less stigmatized and more trusted forms of assistance are preferred and sought out. When it comes to highly stigmatized issues, such as mental illness, Black communities have traditionally turned to religion and prayer (Blank et al., 2002; Murry et al., 2011; Conner et al., 2010). Religious leaders have been sought out as forms of social support instead of professional services as the church is seen as less stigmatized and a more trusted institution within the Black community.

The Black Church

Historically, Black churches have been known as some of the most prominent institutions within Black communities. Other studies often refer to the totality of Black religious institutions as "the Black Church." While "the Black Church" is often used both throughout research and in society, it is important to note that the term is not monolithic. Various denominations would be considered a Black church. However, the term has been used to represent religious institutions that are deeply rooted in Black culture, primarily composed of Black clergy and congregational members, and committed to serving and supporting Black communities through various avenues (Samuel, 2019; Plunkett, 2014). Yet, "the Black Church" is a misnomer.

Traditionally, Black churches served as a safe haven for Black communities. Although churches practice some form of religion, Black churches have provided more than religious services to community members. Since slavery, they have focused on the social needs of Black communities and worked to assist Black families in living more equitable lives free of discrimination and poverty (Speakes-Lewis et al., 2011). Black churches have taken on roles to serve the community socioeconomically, politically, and educationally (Blank et al., 2002). One of the critical attributes of Black churches is that of educating community members.

Impact on Health Perception

Black people have received traditional education (i.e., mentoring) and education regarding other life factors, such as personal health, from Black churches. For instance, churches have developed health programs to address issues such as sexual health, diabetes, and cancer, among others (Weeks et al., 2016; Austin & Claiborne, 2011; McNeill et al., 2018). Though health has been a focus of various educational and informative programs within Black churches, very few churches focus on mental health specifically. However, evidence supports that religion can have positive benefits in one's overall mental health and well-being, such as better psychological health, lower anxiety, and lower depression, to name a few (Jourbert, 2010; Mitchell & Ronzio, 2011). Hence, it would be beneficial for churches to develop more mental health literacy programs.

While there are positive benefits in religion and spirituality, maladaptive coping behaviors can also occur as a result of participation in religious communities. At times, religious leaders have reinforced mental health stigma, which would ultimately discourage members from seeking additional assistance. For instance, Porter (2018) found that pastors

feel pressured to take on the problems of their congregation, which often leads them to remain silent regarding their own mental health. Further, Porter's (2018) study supported that stigma contributes to silence within Black churches as members often hear and believe messages such as "God will solve all the problems" and "good [Christians] don't have these problems." Pastors and ministers are often seen as the "epitome" of a Godly person; therefore, if they remain silent about their problems, they reinforce such stereotypes.

Further, current research supports that younger Black community members are distancing themselves from the church for this very issue. Younger community members want more up-to-date and less stigmatized teaching efforts within Black churches (Cooper & Mitra, 2018). For instance, a participant shared how she was advised to remain silent regarding sexual abuse, a very traumatic event, and to simply pray about it (Cooper & Mitra, 2018). When she realized that praying was not enough, she was motivated to try something different, which led her to distance herself from the church. While younger Black community members do feel disengaged from the church, they are still more religious than younger members of other communities (Pew Research Center, 2018). A vast majority of them still believe in God, believe religion is important, and still pray (Pew Research Center, 2020). Thus, Black churches are still in a unique position to assist their community members with mental health issues if given the right tools. The key to this is to increase the mental health literacy of the leaders within Black churches.

Leaders of Black Churches

One of the oldest affiliations of leadership within the Black community is with Black churches. Leaders of Black churches are often referred to as "ministers" or "pastors." The roles that these leaders undertake are often multifaceted both within the

church as well as the community. They not only take on the role of minister or pastor, but also that of "counselor, advocate, mentor, and educator" (Jordan, 2020, p. 21). Avante (2013) found that African Americans often seek help from their pastors for issues such as unemployment, relationships, anxiety, depression, and bereavement as they are seen as a more credible source. Leaders of Black churches are a preferred source of counsel compared to more traditional services when it comes to personal issues, more specifically, mental health (Samuel, 2019; Jordan, 2020).

As leaders of Black churches, their perception regarding mental health greatly influences the perception of their congregational members, and oftentimes, that of the wider community. However, evidence supports that leaders may not compose the totality of literacy needed regarding mental health as many of them may not know how to respond to such matters and could further stigmatize the issue and alienate community members (Porter, 2018; Avent, et al., 2015). Some studies showed that silence was sometimes a response to mental health issues (Porter, 2018). The act of silence communicated that other community members should also remain silent on such issues and ultimately hide any problems rather than seeking assistance. Other studies showed that there was a gap in pastors' knowledge regarding mental health, which limited their abilities to counsel certain members (e.g., Samuel, 2019; Avent, et al., 2015; Hankerson et al. 2013; Williams et al., 2014.) While such leaders acknowledge and meet the need for guidance, their abilities may not extend past religious or spiritual counseling. Therefore, their guidance regarding true mental healing is limited, and the clergy member may not receive the practical assistance needed. With that being said, evidence supports that Black churches need to adapt their messaging regarding mental health within the Black community to dispel stigmatization

and normalize more formal methods of care. The leaders of Black churches are key to bridging the gap between the Black community and healthy mental health practices.

Black Women Leaders

Historically, Black women have played a vital role in the advancement of the Black community, especially regarding racial issues and self-help guidance. Women such as Sojourner Truth, Mary McLeod Bethune, Maya Angelou, Angela Davis, and many more took on integral roles in key Black movements to propel that community forward. Many attested to the unequivocally important nature of Black women to Black people as a whole. Black women are often referred to as “the backbone” of the community. While they were verbally commended, Black women, unfortunately, were not afforded formal roles of leadership. Formal leadership roles were almost always given to men, including in Black churches (Parker-McCullough; Taylor, 2019).

Men have dominated church leadership (Silk, 2002; Hardy 2012). While no definite percentage exists, it has been hypothesized that men have historically represented approximately 90% of pastors within Black churches (Lincoln & Mamiya, 1990). This high percentage is alarming, considering that women have traditionally comprised most congregational members (Green, 2003). Further, according to the Pew Research Center (2014), more women believe in God, believe religion is important in one’s life, attend religious services, and participate in prayer, scripture study, or religious education in comparison to men. While they played an active role, Black women were still not granted the same opportunities for leadership positions as men within Black churches. Yet, Black women have continuously been the backbone of churches (De Leon, 2013; Gross, et al., 2018). Thus, women were often doing the heavy lifting.

Until recently, Black women have undertaken more informal, gender-conforming roles within Black churches. Stereotypically, women have been viewed as mainly caretakers and educators. Roles that were considered as more “masculine” were frequently given to the men. Women oftentimes took on similar stereotypical roles within the church, such as that of an usher, Sunday school teacher, missionary, secretary, or similar roles. (Shaw, 2008). These stereotypes continuously limited women’s ability to attain more formal/senior-level leadership roles. Further, without actual power, women’s voices were muted and marginalized. Nonetheless, Black women began to speak up regarding inequalities in leadership positions within Black churches over time.

Black women have acknowledged that while a certain “glass ceiling” has existed regarding their leadership within Black churches, they are working to attain more senior-level leadership positions such as that of a pastor (Parker-McCullough, 2020). As evidence supports, Black women are well equipped to earn such positions. Further, Black women have long felt a calling to serve in a leadership role (Parker-McCullough, 2020; Cook, 2010). Women’s voices are not only being heard, but they are also getting the opportunity to insert their perspectives in matters regarding the Black community as a whole. Such a phenomenon is imperative as Black women hold a unique position within society where they can provide standpoints different from the “status quo.”

Further, evidence shows that women have a more transformational approach to leadership which can be vital in Black churches, more specifically pertaining to mental health as it is centered around support and mentoring (Eagly & Chin, 2010). Research also shows that Black women are more resistant and outspoken as leaders (Parker, 2001). Black women’s calling strengthens these standpoints to leadership as they perceive their

leadership role as a life purpose (Parker-McCullough, 2020). Thus, Black women's leadership and communication approaches are driven by their calling. Such leadership could be progressive and necessary within Black churches. For the Black church to truly adapt, a change in messaging must occur from the leadership. Black women leaders can provide such change. According to a recent study, members do not view the gender of their pastor as important (Taylor, 2019). As younger community members have voiced their concerns and desires for change, this study supports that they are open and ready for Black women's leadership. Thus, with community members being more receptive and Black women gaining more senior-level leadership positions, it is imperative to capture their standpoints regarding mental health as leaders within Black churches.

Conceptual Frameworks

Men have long dominated leadership positions within various fields and organizations, specifically within Black churches (Silk, 2002; Hardy 2012). As a result, the voices of other marginalized groups have been unaccounted for and muted. However, leaders who identify with marginalized groups can benefit organizations as such leaders "have learned to negotiate both minority and majority groups" (Eagly & Chin, 2010, p. 220). Black women, specifically, can provide a more progressive perspective as leaders within Black organizations due to their personal experiences and intersectional standpoint. From the Black feminist standpoint, the following section will demonstrate the theoretical significance of Black women as leaders based on their leadership communication.

Black Feminist Standpoint

Black women exist at the intersections of race and sexuality. As Black individuals, they experience racism. As a woman, they experience sexism. However, their experiences

of racism are different than that of Black men; and their experiences of sexism are different than those of other women who are not Black (Delgado & Stefancic, 2017). At the very least, Black women experience racism and sexism simultaneously, which further marginalizes them within each group. Consequently, this experience shapes Black women's view of reality as they are able to understand the realities of an insider and that of an outsider (Collins, 1986; Parker, 2001; Hooks, 1984). This unique standpoint allows Black women to see both their own positions as well as that of dominant systems (Parker, 2001; Collins, 1986). Thus, Black women are able to construct a more complete and accurate view of society in a way that more privileged groups are not (Harding, 1987; 2004).

Black feminism highlights the perspective that Black women stand in opposition to oppressive systems as they consistently confront racism, sexism, and other forms of social oppression (Collins, 1996; 1990). The Black feminist perspective is often explored from the foundation of standpoint theory. Standpoint theory was developed to expose oppressive systems through the collective production of knowledge by accurately capturing the experiences of the marginalized (Harding, 1987). The intersectional standpoint of Black women brings attention to their performative experiences at the nexus of their self-defined identity and the stereotypical identity of Black women created through patriarchy. Through this performance, Black women are constantly negotiating and (re)negotiating what it means to be a Black woman to navigate multiple spaces effectively. From this perspective, Black women's experiences lead them to be naturally solution-driven with invaluable experience at negotiation during moments of turmoil, which is also often seen as vital in

leadership (Parker, 2001). Thus, the standpoints of Black women leaders can serve as essential to understanding more progressive and adaptable forms of leadership.

As supported above, more progressive and adaptive forms of leadership are crucial within the Black church, especially regarding mental health. First, Black churches often preach and encourage outdated forms of mental health coping behaviors which in turn further reinforces mental health stigma within the community. Second, existing leaders are limited in their ability to adequately assist their congregation with mental health concerns due to their limited knowledge. Third, Black youth are distancing themselves from Black churches as they desire more a more progressive and accurate perspective of mental health and mental health practices within their churches. Through their experiences, Black women leaders are in a unique position to address each of these concerns regarding mental health and Black churches.

While Black women can address each of these areas, evidence also supports that their communication as leaders is collaborative, empowering, proactive, and direct (Parker, 2001). With the need for transformation of how Black churches address mental health issues, women leaders will be particularly well suited because mental health issues are caring issues which women have traditionally taken the lead (Wells-Wilbon & Simpson, 2009). Thus, Black women can balance both a nurturing and direct style of leadership. It is beneficial to have a nurturing style of leadership as it pertains to mental health because it is a heavily vulnerable and emotionally laden topic. Yet, congregants still need their leaders to be direct and honest to truly receive authentic guidance toward healing. Further, Black women's communicative leadership style is resistant to dominant and oppressive issues, collaborative in decisions-making, and connected to the overall betterment of the Black

community as a whole (Parker, 2001). These communicative styles are important in progressing mental health practices within Black communities, more specifically within Black churches, as Black women leaders are open to admitting when existing forms of assistance need to be reevaluated and restructured.

All in all, Black women's experiences can lead them to embodying more progressive and well-rounded forms of leadership as they have experience navigating difficult situations and can relate to multiple audiences on varying levels. This foundation of leadership can be monumental in shifting mental health perspectives within Black churches as congregants often follow the lead of their church leaders. If Black women leaders are more progressive in their mental health practices, then their congregation will also become more progressive in their mental health practices. Therefore, it is imperative to capture the standpoints of Black women leaders within Black churches to understand their perceptions and mental health practices. Further, it is also important to understand why Black women choose to become leaders in the church given the historical resistance to women leadership in Black churches. Their motivation and personal experiences will provide valuable insight to understand their standpoint and perspective. Capturing the motivation, personal path to leadership, and perspective of Black women leaders within the church will provide a holistic representation of their paths and experiences. A useful framework for understanding their motivation, standpoint, and the influential nature of their perspective is sensemaking.

Sensemaking

We, as human beings, are presented with copious amounts of information every day. As we are given this information, we are constantly learning and (re)learning to make

sense of our experiences. Each day we piece bits of information together to create our reality and assign meaning to our lives. This suggests that the production of reality directly affects and is affected by our mental health in at least three ways. First, the information we are presented with influences whether we are experiencing positive or negative emotions. Second, the information we are presented with influences the meaning we attribute to those emotions. Third, the information we are presented with influences the decisions we make based on those emotions and the meaning we attributed to them. This is the concept of sensemaking.

Sensemaking occurs when we try to assign meaning to events and decide on what to do next (Weick, 1995). In this process, two questions are asked, “what is the story?” and “Therefore, what should I do next?” The meaning we assign to such events then serves as a springboard for action regarding the decisions we are to make after the event(s) has occurred. The Enactment-Selection-Retention (ESR) model (Weick, Sutcliffe, & Obstfeld, 2005) describes the 3-step process of sensemaking. The first step is enactment, where the actual event has taken place. The second step is selection where one must assess the paths that could be taken and choose one. The third step is retainment where the chosen path becomes automatic, normal, and institutionalized.

We engage in sensemaking every day. Most of the time, it happens effortlessly, subconsciously, and is typically unnoticeable (Weick, 1995). Subconscious sensemaking occurs when we are presented with information repeatedly to where it becomes the norm. For instance, as a Black child who grew up in a Black church, I rarely heard sermons on mental health or saw my peers engage in discourse around mental health. Whenever issues of mental health did arise, I learned that people should just “pray about it” and that was the

extent of any discussion or advice given. Therefore, the information that was presented to me here was that mental health was a topic not to be discussed. Moreover, I was exposed to dialogue around mental health from my white peers outside of the church. This information further reinforced that I was not to talk about mental health because that was for white people. As a child, I was constantly exposed to information that reinforced silence within my community. As a result, it became a norm to not discuss mental health issues or concerns so when such issues arose, although I had the option to address those issues, it was second nature for me to suppress them.

When we engage in sensemaking, we tend to choose second nature paths that are deemed safe to keep us in our comfort zone. Those paths are the ones that we are used to taking. However, safe paths of sensemaking are often maladaptive as they limit our growth and progression (Weick et al., 2005; Weick, 1995). If I always remained silent regarding mental health issues, then I would have never addressed my concerns and worked toward healing and more adaptive behaviors. Further, I would continue to encourage silence among my peers, which would reinforce mental health stigma within my community. While this is true for individuals, it is also true for organizations and their leaders.

When organizations and organizational leaders engage in maladaptive sensemaking, they are not learning. Therefore, they are not adapting to maintain ecological fitness with an ever-changing environment and audience. An organization can remain ecologically fit when identifying changes that need to be made and adapting accordingly to their environment (Poole, 2004; Davenport et al., 2006). However, if an organization encourages maladaptive sensemaking and refuses to progress, the organization will cease

to exist and be replaced by a more adaptive alternative. Thus, it is imperative that organizations maintain ecological fitness in order to survive within their environment.

As a religious and arguably health organization, Black churches are one of the most influential organizations engaged in sensemaking. Many community members refer to theological teachings for guidance regarding many life decisions. As a result, leaders of Black churches often engage in sensegiving as well. While sensemaking occurs when individuals assign meaning to events themselves, sensegiving is when someone influences the meaning others attribute to reality (Gioia & Chittpeddi, 1991). People often seek out sensegiving during times when anxiety is high and the next step/action is not as readily available, or when the situation is not as easy to understand. For instance, this occurs when concerns regarding mental health arise and one's internal experience is contradictory to the typical maladaptive paths taken.

Within Black churches, when anxiety regarding decision-making is high, members often consult their religious leaders for guidance on what to do next. This is when leaders engage in sensegiving. While religious messages are typically taught for the betterment of followers, they can sometimes lead to maladaptive coping mechanisms for life decisions. For example, if leaders of Black churches remain silent regarding their personal mental health issues, they can ultimately encourage their church members to remain silent regarding their mental health issues (Porter, 2018). However, remaining silent is a maladaptive behavior to encourage among congregants. Further, as community members' perspectives and experiences progress, churches' teachings must adapt accordingly to their audience. Thus, if leaders of Black churches do not encourage more progressive forms of healing based on the needs and beliefs of their congregants, younger congregants will

continue to distance themselves and seek other forms of support. However, the process of sensegiving does present leaders of Black churches with an opportunity to change maladaptive behaviors toward more progressive forms of healing. This process is known as sensebreaking.

Sensebreaking occurs when previously attributed meanings of normalcy toward a given event is disrupted (Pratt, 2000). For instance, sensebreaking would occur when a religious leader encourages discourse surrounding mental health and discourages silence as silence has been the norm for so long. The component of sensebreaking is an essential in shifting maladaptive behaviors to more adaptive practices.

The current study will examine Black women leaders' perspectives of and personal experiences with mental health and the communicative messages they share with their congregants surrounding mental health issues. As Black women's leadership approach is driven by their calling to become a church leader, it is important to understand how they came to be in their leadership role and how they make sense of their role as well. The way Black women church leaders understand their leadership role could directly affect the sensegiving messages they communicate to congregants. Further, the opposition that Black women church leaders often experience in attaining their role could provide them with insight regarding mental health issues. While some historical forms of support enacted by leaders within Black churches have been identified as maladaptive, a shift in leadership to Black women leaders could have led to a shift in practices as well. As supported above, Black women leaders often exercise wisdom by acknowledging that everything is not known and are inviting of uncomfortable paths for the betterment of the community. Thus, Black women leaders may be open and encouraging alternative explanations and forms of

assistance for mental health issues other than those often voiced. Further, Black women's intersectional experiences may also provide the tools needed to enact this change and provide alternative perspectives. Overall, the personal experiences of Black women could greatly affect their messaging to their congregations regarding mental health. Thus, leading to the following research questions:

RQ1: How did Black women come to be in a position of leadership within their church?

RQ2: How do Black women church leaders perceive their position of leadership?

RQ3: How do Black women church leaders perceive mental health?

RQ4: In what ways do Black women church leaders engage in sensegiving with their congregants about mental health?

RQ4a: How has Black women church leader's personal experiences with mental health affect the messages they share with their congregants?

RQ5: In what ways do Black women church leaders engage in sensebreaking around mental health?

Chapter 3: Method

A qualitative method designed was used to address these questions. Qualitative methods are appropriate for two main reasons. First, high quality qualitative research is deeply analytically complete and will allow me to ensure my analysis is exhaustive and equivalent (Tracy, 2013). This is imperative to ethically account for all data. Second, qualitative methods allow for the transferability of real-life experiences and the development of sensitizing concepts that are significant in preventing negative outcomes (Tracy, 2013). More specifically, this current dissertation utilized the method of interviewing to capture real-life experiences through the collection of stories (Lindlof, 1995). More information regarding participants, data collection, and analysis are presented below.

Participants

Participants were recruited through email, via an online flyer, and from snowball sampling. Emails were sent to personal emails as well as various organizations such as the Coalition of African-American Pastors and Women of Color in Ministry. Participants were chosen based on three criteria. First, participants were required to identify as a Black woman. Second, participants had to currently hold, or have previously held, a religious leadership position. Third, if the participant was in a current position, they must have been in their position for at least six months to ensure an adequate amount of time has passed to build enough trust for others to consult them with mental health concerns. Regarding first and second criteria, from a theoretical perspective, it is important to include these so the social location of the participants is consistent. The social location of the participants is crucial because it is influential of a social reality shared amongst Black women. These

criteria also identify the participants as examples of positive deviance as they are exceptions to the norm of predominantly male leadership in Black churches. (Bisel, Kavya, & Tracy, 2020).

Interview data collection

I conducted 20 interviews of Black women church leaders. Participants who responded to the research call was scheduled for a Zoom interview through the online scheduling software, Calendly. An email including the Zoom information (link, meeting ID, and password) was sent the day of the interview. Interviews were conducted individually and privately with each participant. Once the Zoom meeting started, participants provided oral consent at the beginning of the interview. Interviews followed a semi-structured interview schedule of 10-questions and lasted an average of approximately 58 minutes, ranging from 36 to 90 minutes (*See Appendix A*). The questions asked reviewed the participants' educational background, personal experience and perceptions of mental health, their experiences regarding counseling congregants on issues of mental health in one on one or family sessions, general leadership on mental health at their church or organization, and their communication to church/organizational members about mental health issues. Questions asked included phrases such as "Can you provide an example…" and "In what ways…" to yield a richer response that represents the interviewee's lived experience. These types of questions also lead to thick description and transferability. Follow up and looping questions were asked such as: "So, in your words, X might be an example, but what about…?" and "When you say, X, what do you mean?". Each interview was recorded via Zoom, transcribed verbatim, and confirmed for accuracy.

Data analysis

Prior to the analysis, I listened to each recording along with the typed transcripts on my computer to ensure accuracy of the transcriptions. Transcription inaccuracies were corrected accordingly. After edits, the transcriptions totaled 159 pages single-spaced.

The analysis took place immediately after the last recording and transcription was checked for accuracy and corrections. A constant comparative analysis was conducted to analyze the transcripts thoroughly and note emerging themes (Glaser & Strauss, 1967; Suddaby, 2006). The analysis proceeded in 5 main stages.

First, I engaged in data reduction. At this stage, I reduced all data and kept only what was relevant to the research questions. I read and reread through all of the transcripts, and only the data pertinent to the current study remained. In the second stage, employed open coding. Owen's (1984) open-coding strategies were utilized at this stage to categorize the data. Based on these strategies, I identified recurring topics and repetitive words. Transcripts were analyzed to categorize the members' experiences. Summative labels were then created to assign overarching meaning to the data. These summative labels became categories of coded themes and interview excerpts. As I read through the raw data, summative labels were developed by asking questions such as "what meanings or topics reoccur" or "what specific words come up over and over again" to determine appropriate categories. Data that attributed similar meanings were be coded under the same label. Data that attributed different meanings were coded under a different, more appropriate label.

After the initial categories, I began the third stage of focused coding. At this stage, each of the categories was compared to other categories to ensure that all of the categories were exhaustive and equivalent. To ensure the categories were exhaustive, I compared the

relevant data in the transcripts to the data coded under each label to guarantee that all the data was accounted for and assigned meaning with a label. If data was not accounted for, an appropriate label was created, and the data was assigned to that category until all data was categorized. This step was imperative to ensure all data was accounted for and to identify any negative cases. To ensure categories were equivalent, categorical labels were compared to other labels to determine that all labels were at the same order of abstraction. Through the process of focused coding, categories were reduced to ensure that no overlap was occurring between categories. The researcher analyzed attributed meaning and interpretation of one category to the next. Categories that were similar in interpretation were consolidated.

In the fourth stage, axial-coding was conducted where the researcher analyzed possible interrelations among each of the categories. This stage also included prospective conjuncture where emerging themes and categorical analyses were reviewed in terms of concepts from past research (Tracy, 2013). Finally, an analysis was conducted to look for associations between the categories and each research question as well as the categories and both standpoint and sensemaking theory. For the categories and research questions, I assessed how each code explained each research question. Upon completion, I determined how the interrelations amongst the categories themselves explained each of the research questions. The same process was conducted between the categories, their interrelations, and the theories both individually and together.

Verification

Creswell (2007) recommends qualitative researchers use at least two validations strategies. To achieve this, first, I provide thick-rich description by including direct quotes

from participants to allow readers to determine the appropriateness of my interpretations and whether the results are transferable. Second, I used peer review in which two experts in qualitative research challenged me to explain methods, meanings, and interpretations. This process of peer review led to some reorganization of the findings but no substantial changes.

Chapter 4: Findings

The analysis of the interviews of the 20 Black women church leaders resulted in eight thematic categories. The categories are listed here, and the corresponding themes are presented below in further detail.

1. Felt a Calling to be a Religious Leader
2. Religious Leadership Exists Outside the Walls of a Church
3. Education on Mental Health
4. Sensemaking of Mental Health
5. Personal Experiences with Mental Health
6. Challenges in Addressing Mental Health Concerns
7. Sensegiving and Sensebreaking regarding Mental Health
8. Rewards in Addressing Mental Health Concerns

The research questions above present perceptions of mental health, sensebreaking messages, and sensegiving messages as separate processes; although the questions can be answered separately, the findings suggest that the responses interact with one another. Table 1 represents each of the themes in correspondence with the specific research questions. Further, the later findings were enhanced with the understanding of the preceding information such as the leaders' life journey to their current role and education. Therefore, the findings will be presented below based on themes to understand the unfolding of and ongoing process of sensemaking, sensegiving, and sensebreaking. The themes are presented under their corresponding categories presented below.

Table 1

Research Questions	Thematic Categories
RQ1	Theme 1: Felt a Calling to be a Religious Leader Theme 2: Religious Leadership Exists Outside the Walls of a Church
RQ 2	Theme 2: Religious Leadership Exists Outside the Walls of a Church Theme 6: Challenges in Addressing Mental Health Concerns Theme 8: Rewards in Addressing Mental Health Concerns
RQ3	Them 3: Education on Mental Health Theme 4: Sensemaking of Mental Health Theme 5: Personal Experiences with Mental Health
RQ4 & 4a	Them 3: Education on Mental Health Theme 4: Sensemaking of Mental Health Theme 5: Personal Experiences with Mental Health Theme 6: Challenges in Addressing Mental Health Concerns Theme 7: Sensegiving and Sensebreaking regarding Mental Health Theme 8: Rewards in Addressing Mental Health Concerns
RQ5	Theme 5: Personal Experiences with Mental Health Theme 6: Challenges in Addressing Mental Health Concerns Theme 7: Sensegiving and Sensebreaking regarding Mental Health Theme 8: Rewards in Addressing Mental Health Concerns

Demographic information will be presented along with results to provide context of the respondent. The themes are presented without consideration to income, location, or age as these variables did not appear related to any variation in the responses of the women. The only two demographic factors that had any impact on the data were denomination and educational degree earned. To clarify, one's chosen denomination did not affect their perception of or experiences with mental health; instead, certain denominations were chosen based on the women's desires in leadership. The leader's degree field directly

impacted the amount of formal education they received on mental health. All participants quoted have pseudonyms chosen by themselves to protect their identities.

Felt a Calling to be a Religious Leader

Nearly all the women leaders referred to their role as a calling or anointment, with the exception of one. During some of the interviews, the women described their road to church leadership in a way that represented a "calling". I would follow their response with questions such as "other women described this journey as a calling, would you describe your life journey as such?" Although it appeared apparent that the women were describing their experience as a calling, this question was asked to both clarify this conclusion and to verify the description of other participants. All the women responded in agreement. Three major themes regarding the calling emerged as a result.

God Called Me to Preach as a Youth

The first theme is that the women felt their calling was guided by God specifically. Rev. Dr. Michelle, a pastor of a southern African Methodist Episcopal (AME) church, shared her experience with God calling her to preach:

> I knew God called me to preach and I knew pastoring would be somewhere in there. I just didn't know when it was going to happen. So, I got it the day after my mother passed away. I was sent to the church I'm in now…And so I think when it really resonated with me that this is the next level God wanted me to do is once I got into the church and started pastoring, and actually on the grounds.

Rev. DeltaRev, a lead pastor of a midwestern United Methodist Church, also shared being called by God:

> Well, that's a story that goes back a long time. I just felt like there was a calling in my life. God was calling me to this work. And some of the background stuff I did just kind of led to the connections I had and that kind of thing. I consider my call to be similar to that of Samuel in the Bible, I heard a familiar voice…So, I've been serving for a long time and served in various positions.

Elder Renee, a preaching assistant of a mega northeast AME church responded with personal path to leadership. She shared her religious experience as a youth seeing her dad pastoring and how that led to her leadership:

> When I was 14 years old, I started in ministry and my dad is a pastor and he's been pastoring for 49 years. So, ministry was just what I did, and you know as a pk (preacher's kid), we really didn't have a choice in being involved in church, but specifically ministry for me started when I was, you know, participating in like youth days and things like that. And eventually just became something that was a part of me and that was evident that I was called to another level.

These three women, and several others, felt they were always destined to be religious leaders within a Church. From a young age, they realized God was leading them to become pastors and they maintained their leadership since.

God called me through my peers

While many women felt they were being called directly by God in some way, two participants felt God was calling them through communication with their peers. Rev. Christine, M.Div., shared:

> I have always been super involved in any church that I have been a part of…in leadership and music ministry leadership. So, I thought I was good. I mean, I was

> like a super church member. But what kept happening to me was that people kept mistaking me for a minister. So, people would call me Reverend…It didn't make sense to me then. But clearly people were seeing something in me that maybe I didn't see in myself. And so, it got to the point where I decided to consider the possibility that being led to something beyond just church membership.

Pastor Danielle, M.Div. expressed similar experiences in needing a push to pursue ordination:

> So, I came a very indirect route into church leadership. I think it's what most black women in particular do. We are not held up as leaders, particularly of congregations. And so, it took a lot of prodding from God speaking through various life experiences, including family members and friends, mostly women, to come to the decision to pursue ordination in the United Methodist Church.

Rev. Dr. Amy, an associate minister for a southern AME church and a Chaplin for the Air Force, overcame various difficulties to ultimately accept her calling. She experienced obstacles as a woman as well as that of natural disasters. Like many of the other participants, Rev. Dr. Amy changed denominations because some denominations refuse to ordain women to a leadership position in ministry. In addition to her transfer in denominations, she also had to transfer universities due to Hurricane Katrina. In the end, she was able to serve as a leader through various ministries:

> I was part of a denomination that didn't ordain women…I definitely had some challenges just kind of moving forward…And so when I transferred [universities] and had another female chaplain and she was very, you know insistent like you need to go to seminary. And so basically with her support and my mom really was

> pretty much all I had as you know really strong people…I went to Divinity School and decided to take up the Chaplin candidate program, which is in the Air Force. So not only am I ordained in the Episcopal Church, I am also a military chaplain.

Although these women ultimately accepted their calling to pastor and becoming a leader within the church, their responses describe the influential nature of the community. Motivational communication was key in their experiences of overcoming. Without the push from their peers, these women may not have accepted their calling by God. Through the voice of those close to them, God was able to get these women in a position to share their ministry.

Took other routes before accepting my calling

While many of the women shared religious childhood experiences along with Elder Renee, such a being raised in the church, most of the leaders took a nonlinear path prior to accepting their calling. Some of the women originally sought a different educational route in preparation for a career outside of ministry. Pastor Katherine, M.Div., the lead pastor of a southern United Methodist Church, expressed her initial path to be a doctor:

> I was actually originally pre-med. I went to school, got my degree in biochemical sciences. My whole life plan from seventh grade was to be a doctor. And well God had different plans for my life than I had for myself…I worked in biotech for 10 years. Then I started working at a faith-based non-profit, working on homelessness. Then fully answered my call and I went to seminary.

Rev. Rebecca, an associated pastor for a southern United Methodist Church, shared a similar story where her initial educational path shifted as she accepted her calling to ministry:

> I actually thought I would l be doing something similar to what you are, I wanted to psych major…So, I went to school to be a clinical psychologist and I wanted to specialize in art therapy. And then my junior year I got the call, the official call to ministry, and then shifted my focus more into religious studies. And then I went to seminary following that. And I've been doing this ever since.

In both of these cases, the women initially took different routes in life. Ironically, they strived to do work to help others through healing. While they ultimately accepted their calling to pastor and leader within a church, their previous routes still set a foundation for their leadership.

Religious Leadership Exists Outside the Walls of a Church

When the interviewing process initially began, there was an underlying assumption that the women were religious leaders for a particular church. While many of the women were leaders within churches, findings indicated that Black women undertook varying religious leadership roles rather than *church* leadership. In other words, some of the leaders engaged in ministry from organizations other than that of a church.

Rev. Christine, M.Div. described her experience and transition to ministry outside of the church. She served as part of a pastoral team for a northeastern United Church of Christ, then transitioned her leadership both to the city of Faith-based and Interfaith affairs, as well as a professor of theology and religious studies. The reasoning behind her transition was due to her being the only Black person of leadership within her church. As the only Black leader, she felt isolated and wanted to do more justice work for the Black community. Rev. Christine, M.Div. stated:

> It was very hard for me to be there and feel isolated and alone as the only Black person there. We were right in the thick of it, you know, Michael Brown was killed. Then, Tamir Rice was killed, and I kept wanting to bring us forward as it relates to our justice worker. And we started a social justice ministry there. And we went to rallies together and made signs and protested and all of that. But it felt like I was forcing their hands instead of it being something that they were freely and enthusiastically doing…Since then, I've been doing faith work outside of the four walls of the church.

Rev. Christine's, M.Div., personal experience as the only Black person in leadership led her to consider other opportunities to lead outside of the church. Her words imply that the lack of perceived authentic support regarding social justice issues for her community translated as a lack of support of her. Her transition to Faith-based and Interfaith affairs at the city level provided her with the opportunity to provide religious leadership and comfort to her community:

> I also see myself, as you know, it's interesting, I'm not pastoring {a} congregation in a traditional sense…{but} I've had the opportunity to create space where I can kind of pastor the city. I mean, each person has their own faith tradition, may have their own religious leaders that they are in community with. But especially during COVID, I've been able to create space where people feel attended to spiritually during this difficult time.

While Rev. Christine, M.Div., is not pastoring in the four walls of a traditional church, she is able to still provide pastoral care and spiritual support to the community through her job with the city. Rev. Christine, M.Div., also shared sentiments regarding her teaching as it

provides another avenue to connect with other communities, more specifically young adults. She can provide ministry to help her students engage in conversation regarding spiritual connection and formation with others to encourage reflection through her teaching. She believes in allowing those receiving ministry to have the freedom and flexibility to have their own beliefs and to think critically about where they stand. This is an integral connection between her perceived purpose in normalizing communication around religion.

Similar sentiments were shared by Rev. Dr. Grace, the Executive Director of a mentorship network that serves women of color in clergy positions around the country. She shared:

> Well, I used to be an associate pastor, but I work with women in ministry. And so, my quote church is very nontraditional. So, I am not currently a pastor of a physical traditional church. So, it's not church the way you would think of church…They [the mentees of her network] may be assistant pastors, they may be senior pastors, and I help mentor them. So that's a very different kind of ministry…And there are a lot of young women in ministry, even, mid-career women in ministry, who are finding innovative ways to do ministry outside of church. So, their demographic may not include a physical building, but they may find ministering and pastoring in other ways.

Although Rev. Dr. Grace was previously a traditional church pastor, she has expanded her ministry to mentor other upcoming women in ministry. She has recognized that ministry is transitioning and has allowed for that freedom of pastoring both within her organization and as well as for her mentees.

Rev. Dr. Cereza Luisa, a minster for a midwest AME Church, also shared similar accounts:

> But it [her calling] has always been active in caregiving, activism, communal activism, global activism…I have been able to engage in accompaniment with persons in Central and South America - certainly working with persons who have been homeless and mentally ill, the prostituted, persons who have been incarcerated or were incarcerated or coming out of incarceration. A lot of my work is social justice oriented, as opposed to just pulpit or pastoral ministry in the context of a church building.

While she is still a part of a church, Rev. Dr. Cereza Luisa still sees the benefit of providing ministry outside of the church especially for social justice purposes.

These women all felt that ministry and pastoring had an important place not only within the walls of a church or congregation, but also for the larger community outside the physical church. It was imperative for these women to organize communication around religion and ministry in the direction this new transition is going. As shown above, the reasoning for this shift in ministry leadership occurred to expand connection and support to other areas of the community and due a shift in the perceptions and preferences of young adults. Therefore, in order to serve the communities, they actually wanted to connect with, the leaders had to shift the home of their ministry.

Education on Mental Health

All the women received some level of formal education. 5% of the leaders received an associate's degree, 70% received a master's degree, and 25% received a Ph.D. When it

came to education regarding mental health specifically, their knowledge level varied based on their specific degree. This led to the two themes presented below.

The seminary route provided minimal, but some mental health education

Those who went the educational route of religious studies such as a seminary or theological program received some level of education regarding mental health concerns. However, the findings overall suggest minimal training. Still, the actual number of courses, if any, some leaders took that covered mental health depended on their chosen program.

Evangelist VJK, a pastor of a northeastern Church of God in Christ (COGIC) church, shared her experiences in only recalling popup conversations between students regarding mental health. She stated:

> I wouldn’t say there was a lot of talk about it. It came up but I didn't necessarily have a class on it or anything like that…I really don't remember {what was discussed specifically}. I don't remember any kind of training around it. If there was anything that was said it was probably something that came up in class conversation amongst students, but I don't remember there being anything formal in the training, or classes, or professors.

Pastor Danielle, M. Div., alluded to basic psychology courses as well as clinical pastoral education (CPE) as her extent of mental health training. Yet, she also expressed how she may have needed more education, such as a separate degree:

> Not as much probably as I needed to. I probably needed to go ahead and get a separate degree. But yes, so part of getting your Master of Divinity is that you go through…involves doing pastoral work in a secular context. So, part of getting yourself prepared for that is you might have a year of very basic psychology,

> right? And it’s more than psych 101, right? But it's less than a real program. And if you become what they call a resident, then you probably get another year of it if you do all four quarters…So yes, there is some basic training.

Overall, Pastor Danielle’s sentiments supports the need for more in-depth training regardless the educational route taken. For the seminary route, nearly all the other women agreed with such experiences of minimal mental health training provided through clinical pastoral education (CPE). Some participants shared that their experience with CPE was more focused on physical health issues than mental health. Pastor PG, one of the founding co-lead pastors of a northeastern nondenominational church, shared:

> No, not mental health. I did a clinical pastoral education placement at a hospital, so I did 400 hours of CPE as a pastoral intern…but it certainly wasn’t a focus at all anywhere. It was like you shouldn’t call folks crazy. You shouldn’t make analogies to whatever you’re trying to describe, saying people are bipolar and schizophrenic, which was popular in the pulpit, I say like a decade ago…but it never was a focus unless you opted to do courses at the Public Health School or whatever else.

Pastor PG iterated points regarding the lack of specified mental health training. She did discuss the aspect of communication when it comes to discussing a person’s mental health. Although Pastor PG did recall these conversations, they appeared to occur sporadically and informally rather than formally, which led to a lack of focus on such issues.

While CPE provided minimal training, other participants took additional courses to supplement CPE and receive more in-depth education. Minister Rae, a program coordinator for a collegial ministry foundation, expressed:

> We have to take a semester of pastoral care, which gives you a very basic level introduction to what you may encounter with congregants if you choose to pastor in a full-time role in that kind of ministry. And because I knew that I was interested in pastoral care and practical theology, I took additional courses that fortified those things because I knew that I was going into what I'm doing now. So, I needed the resources, the information, so that I could have these types of conversations with people like *'so I'm a Christian but I don't think I should be going to therapy. What should I be doing?'* And I'm like you need to be going to therapy.

Two other participants enrolled in seminary programs where they received a bit more extensive education on how to handle mental health concerns. Both leaders shared how they were required to take a counseling track. Rev. Dr. Haddie Mae, an associate minister for a northeastern Baptist church, entered a program that shifted their track requirements to include counseling in mental health courses. She shared:

> In seminary, we had to take a counseling track. The counseling track for us was new because they had just developed a counseling program. And so, before the counseling program was developed, that wasn't a part of your track. But as M. Div. students, I think we had to take about three or four mental health or pastoral counseling which was in counseling mental health classes. And, and those are some of my favorite classes.

Rev. DeltaRev shared her experience in taking pastoral care and counseling in addition to CPE:

> I went to seminary and it was a requirement to have a course in pastoral care and counseling. And the very first thing that we were told on the first day of class is

> that every pastor needs to be in a therapeutic situation, of their own…And we had a list of persons in the area that we could sign up with for our time while we were in seminary. There was also a requirement of what's called clinical pastoral education where you spend so many weeks in a setting, that's either a hospital setting or some people were at prisons, nursing home, some of the kind of setting like that where you spend a certain amount during the week, whether it's a day or two days. Then you come back, and you talk about your experiences and what you learned, what you felt, all that stuff.

Rev. DeltaRev's educational experience not only highlighted the importance of gaining experience in pastoral care and counseling, but the pastors also needed to take care of their own mental health. Her program and specific courses provided personal resources as well as the opportunity for their students to discuss their experiences in pastoral care and counseling as a debriefing session. Rev. Rebecca shared similar sentiments in her educational background focused on the health of the pastor:

> I will say very little. So, so we stress the importance of mental health and taking care of yourself and seeking therapy when you needed it and self-care and all those things. But there wasn't, I wouldn’t say a ton of emphasis on mental health.

Overall, all the women received some discussion on general mental health concern. Some of the women could only recall informal discussions outside of course material while other women received a more formal educational background of mental health training. In a few of the programs, their extent of mental health discussion was regarding their personal mental health as pastors. While all the

women could recall some discussion, many expressed their level of education as minimal and were in support of more classroom training with mental health issues.

A degree specifically related to mental health provided more extensive training

Some leaders received degrees that yielded more specialized mental health training. First Lady Sharlene is a school psychologist in an urban setting where her work experiences have allowed her to understand mental health more thoroughly. Minister LaKeisha, an associate minister for a northeastern Baptist church, holds a master's in social work and is the owner of a business that provides counseling and communicative assistance on ways of healing. Her educational route afforded her the opportunity to focus specifically on mental health. Rev. Dr. Grace is also a clinical social worker by training. Having this formal training allowed her to merge the scientific with the spiritual. Rev. Dr. Grace stated:

> I have an MSW. So, I'm a clinical social worker by training, licensed by the state. And I brought my clinical skills to the context of ministry and have worked with trying to integrate spiritual health within mental health. And also try to help mental health and form and shape ministry so that there is an intersection and an interdependence of the two when we think about wholeness.

Rev. Dr. Amy's experiences in the military have provided her with a unique background where she has been exposed to more mental health training. She shared:

> I will say in pastoral care in theology, I did have a little bit of an introduction, but it wasn't extensive. Now when I got that to the military, we talked a lot more about it. And specifically, PTSD, moral injury, just general depression, and I guess you

> could say like depression spectrum disorders like bipolar disorder management. So, I got more exposure and the military then in like civilian school training.

The additional, more specified training these women received provided more training for them to understand how to handle mental health concerns on more of a practitioner level. Their additional training also afforded them more hands-on experience in dealing with mental health issues prior to, or during their pastoral roles within the church.

Sensemaking of Mental Health

All the leaders highlighted the importance of mental health when asked about their personal perceptions. Their responses were supplemented with an explanation of what comes to mind when they think about mental health in a general sense. Three themes resulted which are discussed in detail below.

Mental health is dealing with life stressors

Some of the leaders connected mental health with functionality regarding life experiences, mainly challenging experiences. Within their responses, some of the leaders referenced one's ability to "bounce back" after a certain amount of time. First Lady Dr. Zeta, a president of a southern college and the first lady of a Baptist church, expressed these sentiments:

> I guess not to sound so cliché-ish, I would say [mental health] is 'are you okay with not being okay?' How are you functioning dealing with the stresses of life and the stresses of leadership? Like are you taking care of yourself that when bad things happen you can kind of brush it off after a day or two and it not just consume you. So that's how I would think of it.

Rev. Dr. Cereza Luisa connected mental health to her identity as a Black woman and the different challenges certain stereotypes brings. A Black woman's ability to be comfortable with who she is despite the expectations placed on her represents good mental health. Rev. Dr. Cereza Luisa stated:

> I just think…that for Black women in particular and mental health is being able to live into whatever you're feeling. And that it's not stigmatizing, shameful, but there is a healthy benefit. And also recognizing that you might need a balance and that you need a balance and that it's okay to ask for help and you don't have to live it to the stereotypes that had been portrayed or what societies placed on you. So, for me, mental health is I'm good with who I am and I'm at peace with who I am, my messiness and all.

For both these women, mental health related to one's ability to overcome the difficulties of life including with one's identity. Rev. Dr. Cereza Luisa understood that our identities come with stereotypical expectations and at times those expectations can be debilitating. In the end, according to these women, one reaches a good level of mental health when they are able to overcome such hardships and seek assistance when needed.

Mental health means wholeness

Many of the leaders alluded to wholeness and how mental health is the totality of our emotional, physical, and psychological selves. Our ability to understand and recognize not only our behaviors but also that in which influences our behaviors composes our mental health. Pastor Danielle, M. Div. shared:

> When I think mental health, I think wholeness. So, when you are able to weather the storms of life and still be healthy, and still be happy, and still try and maintain communal connection…But I think it's more than resiliency, it's about being able to be resilient and transform to a better place after the difficulty.

Rev. DeltaRev and First Lady Sharlene touched more on the process of mental health where our mental health is maintained in rhythmic nature. The interplay of our psychological awareness and behavior control determines our level of mental health stability. Rev. DeltaRev shared:

> It means having not just your mind in sync, but your body and your whole being kind of in a certain rhythm…In the kind of rhythm when there are ebbs and flows, you have a place to look at and to experience and talk about that and reflect on it and see how it affects you. Because the things we do and the things we think about affect how we live, affect how we eat, how we interact with other people, how we view day-to-day stuff.

First Lady Sharlene alluded to the variable of triggers in the way people process life and how identifying those influence our mental health:

> Mental health is identifying triggers, first of all, that may affect a person's decisions, affect their own ability to understand and process life. And the whole goal in mental health is to get people to a place of functionality so that they can go about their daily routines and daily life. And at some point, exercise something to the point where they're happy, where they can find fulfillment. Or things that have happened in their past, they need to be able to know what those things were and know where they fit in that particular situation.

While the focus of mental health is often psychological and emotional stability, these women highlight the importance of other aspects. One's physical health can either negatively or positively impact one's overall mental health. Therefore, it is imperative that people focus on all aspects of their life in maintaining a healthy lifestyle and a level balance of mental health.

Mental health needs to be destigmatized

Overall, a majority of the leaders emphasized the need for mental health illness and treatment to be destigmatized. They connected destigmatization to various aspects of mental health. Sidney, the director of community connections at a midwestern United Methodist Church, stated:

> Mental Health to me means the ability to erase the shame or the stigma that is aligned with people that need help. And I think as a person in the community of color, we don't like to talk about that, or we don't want any know that I need help.

Sidney made a strong connection between mental health stigma and the Black community specifically. At a community level, the concept of mental health needs to be destigmatized. They key to destigmatizing the concept of mental health is focusing our communication on the normalcy and importance of everyone managing their mental health.

Minister LaKeisha expanded the conceptualization and experience of mental health to everyone:

> Mental health means everybody because we all have mental health, right? And sometimes people, when they think about mental health, they think negative. They think that mental health is schizophrenia or mental health is bipolar disorder. But everybody has mental health. Some of us need some help balancing it because we

> all have experiences in life and some of those experiences can be traumatic and an impact us greatly in how we're able to move forward in our mental health.

The focus of some responses was that mental health is just as important as physical health. The participants presented this comparison to raise the importance and normalcy of mental health to the level of physical health as a way of destigmatizing mental health. Pastor PG described mental health as:

> Wellness, chemical imbalances, something that like medicine can help. I think that mental health for me is as normative as like other areas where you need like doctors to prescribe X, Y, and Z for you to be well. So, we are wellness is like the first word that comes to mind, but try and normalize it within the other, like illness or need that like you would need professional support for.

Each of these women supported the importance of destigmatizing mental health. A few alluded to the need to normalize mental health assistance. One should seek help for their mental health as they do for their physical health. Rev. Dr. Michelle drew a connection between the stigma surrounding mental health and fear of the unknown as a result of stigma and the lack of communication as she states, “It’s really scary because it’s multifaceted…And with it being such a taboo topic, is it a history of it in the family?” The connection here highlights the significance of communication in destigmatizing mental health. The lack of communication has led to stigmatization and the increase in communication will lead to normalization.

Personal Experiences with Mental Health

All the leaders shared various experiences they encountered in their personal lives that shifted the way they perceived mental health. For all of them, it encouraged a more

open-minded and intentional approach to addressing mental health not only for themselves but for their wider community as a leader. Two major themes emerged as a result.

Sought out therapy or assistance

When some of the leaders encountered personal experiences with mental health, they sought out professional counseling to help get them through that challenging time. Pastor Katherine, M. Div, went through a time where she was feeling overwhelmed from the many responsibilities that she held both in her professional and personal life. As a pastor, mother, and her mother's caretaker, she had many roles in which she cared for others in addition to completing her ordination preparation work. She had a lot on her plate. Around this time, she placed her mother in rehab for a health challenge despite her mother's reluctance to go and her son was going through personal issues. It was at that moment when she realized she was reaching emotional exhaustion. She shared:

> I will absolutely admit that I was, I was at the end of my rope. I had started driving, you know, thinking am I going to come take my mom out of this rehab? Realized I couldn't. I drove halfway there, had to pull over in a public park a lot and I just cried. And I realized I was at the end of my rope.

Once she pulled over, Pastor Katherine, M. Div., immediately reached out to a counselor through an employee resource program. She continued:

> But what I did though is at that point I did call our EAP (employee access program). So, it's where you can connect to whatever types of resources you might need…And one of it is access to therapists like 24, 7 access to therapy…So it's more like crisis counseling… I knew I needed more help than my friend that had been walking with me and, you know, saying you're doing the right thing…I called

> them, and for that first call, was on the phone for about an hour. Can they talk me down?

The overwhelming nature of these moments, which each called for its own level of urgency, led to a breakdown that caused her to shift attention to her personal mental health needs. She extended herself to assist everyone else and that eventually took a toll on her own health. In order to keep going and maintain, she realized she had to have some sort of assistance for herself and talk therapy was key for her at this time.

While some of the leaders sought assistance as a result of mental exhaustion from taking on the trauma of other's, other leaders' mental health needs were triggered through reflecting on the experiences of others. Minister LaKeisha experienced her personal shift inward regarding mental health in a therapy session with one of her clients. Prior to that moment, she internalized the strong Black woman stereotype and thought she could push through any experience. The messages she consistently heard throughout her life regarding what it meant to be a Black woman led to unhealthy coping behaviors. She soon realized that this perception led to destructive behaviors such as a short temper, promiscuity, and other negative behaviors. She stated:

> It was almost as if I was looking myself in the mirror, like this client was extremely similar to myself. And I remember leaving that session and…calling up the supervisor…I just broke down crying and I'm like, oh my God, my client is me. I need to get my stuff together. Like what is wrong with me? And that's when she said, well, maybe now you need to go to therapy. Because they tell us as clinicians, you should go to therapy because you are going to be dealing with other people's trauma…So, I definitely had to do that.

As a result of this experience, Minister LaKeisha finally opened up about seeking therapy for herself not only for the sake of internalizing other people's trauma, but also to heal from her personal trauma. Helping others to heal served as a gateway for her to look inward, authentically, and seek that for herself. These personal experiences led the leaders to become more open with their communication and sharing their personal narratives as a success story to destigmatize mental health issues and professional assistance.

Becoming more intentional regarding mental health

Encountering personal experiences with one's mental health pushed some of the leaders to become more intentional regarding the importance of mental health. It also shifted the way some of them communicated about the mental health of others and to others. Rev. Christine, M. Div. had been attending therapy which was very liberating for her in terms of feeling free to discuss stigmatized issues such as one's sexuality openly. It was not until she was forced to see a psychiatrist, where she was diagnosed with attention deficit hyperactivity disorder (ADHD), in which her attention really shifted inward regarding how stigmatized mental health and more specifically, mental disability is. This experience led Rev. Christine, M. Div. to become more cognizant of how she communicated about mental health as a leader. She shared:

> I had saw a psychiatrist for the first time…And it forced me to confront the way ADHD sometimes feels like a gift to me and the way it also feels like a hindrance…So, seeing this as something that helps me and something that can potentially hinder me is a new way that I am approaching disability in general. Like it makes a difference in how I talk about healing and bodies and disability when I'm preaching, for example, or when I'm teaching.

Rev. Christine’s, M. Div., personal experiences with ADHD and working through her own healing served as a personal awakening to become more intentional in her messages around healing. Her goal became acceptance and management of one’s mental situation rather than fixing one’s mental situation.

First Lady Dr. Zeta shared a personal experience where her husband attempted to commit suicide. She shared that while her family is still working through it, she and her husband have taken steps to ensure frequent check-ins and mental resets. She shared:

> You really take it one day at a time…Two things that I do, for him every morning I ask him how did he sleep? If he sleeps well, I know that mentally, he's in a better place…And the second thing that I did to try to deal with it; I actually go and exercise in the middle of the day…But that middle of the day caring about me kind of makes me aware. It allows me to focus on me and something that's totally benefiting me and no one else.

This experience encouraged her to be more intentional about focusing not only on her husband's mental well-being but also on her own. Before this experience, First Lady Dr. Zeta expressed that mental health was something distant, “something that was over there.” Going through such a challenging time led her to grow a greater appreciation for the sacrifices and work caregivers give.

Challenges in Addressing Mental Health Concerns

As the leaders were sharing their experiences, they included various challenges that came along with being a mental health advocate as a religious leader. Three major challenges were identified. The challenges identified stemmed from historical practices and teachings that further stigmatized mental health and seeking assistance. Further, these

challenges increased the difficulty of engaging in sensebreaking and working toward shifting the narrative and perception around the concept of mental health.

Challenge 1: Stigma

The biggest challenge identified in addressing mental health concerns in a religious setting was the stigma surrounding the perception of mental health. Many of the leaders emphasized how the church reinforced stigma and much of that stigma still exists. Pastor Katherine, M. Div., shared, “I think it [the challenge] always is breaking down the stigma for congregations. You know, that's something you sweep under the rug. People joke ‘*oh you know uncle so and so is not right’,* but not really addressing it”

Rev. Dr. Grace agreed that stigma creates a great challenge when trying to shift the narrative regarding the importance of mental health as stigma leads to fear of being outcasted. She expressed:

> The stigma. The pushback. The fear of being stereotyped, being considered abnormal, different…And people fear being othered. And Black folks, especially because there's been so much othering on so many other issues it’s like no, I can't risk it, don't want to risk adding another level of othering to my already fragile insensitive identity.

Rev. DeltaRev highlights the prevalence of stigma within the Black community specifically and how our families perpetuate it. She expressed the key to removing stigma is to educate the community with legitimate sources and references.

> I think in all settings…there's a stigma…I think more so in the black community. And I've seen in my family, where people are like, well, I don't need to do that. I don't need to go there. It’s like, yeah, you need to be the one sitting in the

> front, you need to be there every hour…But most for sure there's a stigma and that’s across communities. I think we have gotten to the point now where we find more what we think are answers on things like Facebook and Instagram and stuff like that. And that's not what you need to be doing. So, I think that one of the things is to remove the stigma and to find the legitimate places to go for it.

Each of these women expressed concerns of stigma in the church, their families, and their communities overall. This stigma discourages people from seeking assistance and acknowledging that they have mental health concerns in general, and there are times when they may need help managing them. To normalize the concept of mental health and seeking assistance, the stigma must be erased. For stigma to be erased, a different narrative must be communicated.

Challenge 2: Dispelling Myths

Some of the leaders share how the media and social media further perpetuate myths regarding the concept of mental health which discourages people from accepting it and realizing that everyone has mental health issues at one point or another. In the end, people associate the myths with mental health and are afraid of being associated with such myths. Pastor Katherine, M. Div. reiterated such sentiments:

> …some of it is fear. You have like these mass shootings and they instantly {say} it must be a mental health issue, when the majority of people with mental health issues aren't violent…In media, we associate mental health with violence and that's not necessarily the case. And so it's breaking down all of those misconceptions and myths. And then, you know, you get that spiritual, breaking down that spiritual but

> you just need to pray about it. You just gotta lay hands. You gotta have enough faith and Jesus can help you.

When negative associations are the norm for mental health and illness, people are discouraged from accepting their own mental health issues and seeking assistance when needed. This causes a barrier when the leaders are working to shift the norm and dismantle the associated myth.

Rev. Dr. Michelle agreed that social media paints an unrealistic picture regarding reality and encourages an unhealthy expectation of life. Therefore, when challenges do arise, many are discouraged from being vulnerable and sharing their experiences or seeking help because they do not want others to see them differently. She stated:

> Being vulnerable…If it's you, you know, most of us don't want people to know. That's the whole premise behind social media. You get to have the life, you want to have, or you think you have and most of us want to appear happy at home. And in reality, there are times where all of us become fragmented. I think just being vulnerable, being able to say, you know, I'm hurt…And the reason why we don't know how we're going to be treated afterwards. We don't know if we're still going to be respected – if we're still going to be valued.

The distorted images of life shared online encourages this unrealistic expectation of perfection. If someone is not meeting that expectation of perfection, they are likely to hide it out of fear.

Rev Christine, M. Div. highlights the myth of cure regarding mental health, which is prevalent amongst Black people within the church. However, the expectation of cure deflects from healing and promotes an unrealistic expectation of faith. She shared:

> So I think the other challenge is helping to dispel the myth that the goal is cure, instead of…healing and wholeness…I think in particularly among Black people, you know, we want to shout when Jesus lays hands on the person, and makes them cured, right?...And until we're cured we ain't shouting. And I'm just like, no, because some of us ain't gonna be cured, right. We just have to learn how to live without the bodies that we have. And we miss out on the gift…that our bodies are to us.

All of these women have highlighted various myths associated with the concept of mental health that strengthens stigmatization. Further, the myths are perpetuated within the media and influence people to hide illnesses, specifically psychological or emotional ones. Yet, each of these women are working to change that narrative. When these leaders are working to shift that narrative, they are engaging in sensebreaking against the challenge of fear and myth associated with mental health. Their goal is to break down and disassociate all of the myths from the concept of mental health to create a new narrative and a new form of sensemaking.

Challenge 3: Socioeconomic Inequalities

Many people are limited in their resources, and a lot of that is due to socioeconomic inequalities. Rev. Dr. Cereza Luisa emphasized this perspective:

> Everybody can talk about get a therapist, but what does that do when you don't have any money? What does that do when you don't have your health care or health care that's going to pay for the therapist or the insurance company says, yeah, you can get it and you're on a six-month waiting lists or 10 month waiting lists.

Rev. Dr. Grace agrees with similar sentiments that great inequalities still exist while we

have made progress in normalizing mental health. She further drew a connection between educational privilege and the destigmatized mindset of mental health and therapy:

> Clearly a major progress that we've made and clearly many people who have embrace therapy. But I think that's a socioeconomic dynamic related to people who could perhaps afford therapy, have received perhaps an educational privilege and understand therapy differently than people who are in the lowest socioeconomic strata and have not really received the kind of trust of the system, if you will, that other people have experienced.

While the leaders are all destigmatizing the concept of mental health and encouraging wellness holistically, there is also a clear understanding the everyone does not have access to adequate mental health resources. These inequalities cause a great barrier because even if mental health is destigmatized, people will still be unable to seek assistance if resources are not available. This barrier highlights the structural inequalities within our system, which has further placed a strain on certain communities. Until these disparities are addressed, mental health treatment will not be available or affordable for everyone.

Sensegiving and Sensebreaking Regarding Mental Health

Leaders engaged in both sensegiving and sensebreaking when addressing their congregation collectively as well in one-on-one situations. The women were intentional in sharing messages to combat the traditional stigmatized messages such as those shared in the previous section. These messages served as sensebreaking because they provided new ways of perceiving mental health and assistance other than “just pray about it” or “trust God.” The leaders wanted whoever was receiving their messages to feel supported, safe,

and encouraged to seek help if needed. There were various channels in which the leaders chose to deliver the messages depending on their preference and audience. These findings resulted in five major thematic channels.

Scriptures

The first avenue leaders engaged in sensebreaking was through scripture. The leaders would relate a particular scripture to real-life experiences to encourage the normalization of mental health. These messages would serve as a metaphor for experiences with mental health issues. If those within the Bible went through such challenges with mental health and found a way to heal, then the same can be said about people today. Pastor Katherine, M. Div., described a scripture she uses when preaching to promote the utilization of resources for mental health issues. Mental health is something everyone has, just like any other type of health, and there may be times when one may need to seek out help to make it through, and that is okay. Pastor Katherine, M. Div., shared:

> I was probably talking about one of the cases where a person had been freed from demons, you know legion or something like that. The discussion was back in the day, {where they said} people were demon possessed, but actually {had} mental health issues. And so, that would have led me to stay to talk about yes…just like you have physical health, we had mental health issues…There's some things you just can't pray away…So just like God gave us doctors to treat diabetes, high blood pressure, heart disease, we go have surgery. You need to do that.

Rev. Dr. Cereza Luisa shared a biblical story to help her congregants understand that various obstacles exist, such as stigma and the negative labeling attributed to mental illness, to discourage them from getting the help they may need. This story communicated

the message that many people simply turn to spiritual faith for assistance, but there are times when people need help from a professional outside of the church or spiritual realm and that is okay. Faith will not always deliver them from their challenges, but there are resources that can help them, and it is perfectly acceptable and encouraged to use them. She stated:

> I've talked about the quote unquote with the demoniac…But I just talk about how this guy, he's got all this internal stuff that is going on and that there's liberation…And I talk about even just for him to be labeled the demoniac implies so much because that's what people had come to perceive about people who are mentally ill or mentally unstable…I really try to teach…that we have to be so very clear that any one or all of us are all at the edge…It takes one incident to change how we perceive and how we act. For me it is always speaking healthy and speaking affirmative and reminding people that. It's okay.

Overall, their message was designed to normalize communication around mental health in relation to biblical stories. Many of the leaders acknowledge how the church has historically further stigmatized mental health. Therefore, when they engage in sensegiving about mental health to their congregants, they are intentional about normalizing two things. First, the fact that everyone has mental health issues. Second, it is okay to seek help when needed. Thus, the messages these women shared around the idea of mental health served as sensebreaking to shift the stigmatized narrative the church has created in the past.

Social Justice Connection

Other leaders focused more on mental health messaging when racial issues surrounding the Black community occurred. Some of the women shared messages around this time due to the vulnerability and vicarious trauma Black community members often endured when witnessing and experiencing racist events. These messages served as a form of support, a safe place to reflect, and a reminder for community members to take care of themselves and to be attentive to their mental health. Rev. Christine, M. Div shared a moment when she spoke to community members after a police shooting occurred in her community:

> We had a police shooting here…And I started having these [zoom gatherings for immediate colleagues] in the wake of that because we were Black employees working for the city right after a Black man was killed by two White cops in the city. It just felt like we needed some place to be together and vent about what it means to be a Black employee at this time…I was saying to people, you know, something spiritual. I mean, it wasn't religious. But I was like, this is what wholeness means. This is what wellness means, right? You are not a robot. You don't need to respond…like you're a machine. You don't need to like put on your mask at work and not act like this is getting to you or whatever.

Rev. DeltaRev approached conversations around race in a more general sense to encourage healing between communities through education. This particular experience stood out as she was not in a traditionally Black church. Instead, she encouraged these conversations amongst white congregants as well:

> And so we've talked about during Black History Month, one month, we've talked about issues around race…The words we use, words that hurt and words that

> heal. We talked about white privilege…When Selma came out, I showed a clip of the movie and I said, this happened in the 1960s, but it still happens in the 2000s and let me tell you how…So yeah, we we've been up front and they've, you know, they've had some hard conversations.

Although the receiving community of these two messages were different, both leaders shared sensebreaking messages to encourage attentiveness regarding Black experiences, self-reflection, and focus on healing.

Direct Connection to Mental Health

Other leaders engaged in communication that explicitly focused on mental health. Pastor PG held a preaching series called Medicine, Melanin, and Mental Health where they promoted mental health awareness and wellness amongst Black people. During this series, they would reference various books written for Black women/girls and bring in influencers to also share messages to destigmatize mental health. She expressed:

> Last March…We preached every Sunday about mental health awareness and wellness…And then this year, we didn't do a full one month but we had that particular week that was more focused on wellness. And we had this young woman who does a virtual space (social media), I guess you could call it. And she has this t-shirt that says like, it's okay to pray and go to therapy. So, we brought her and had a conversation with her about wellness and mental health and that was well received.

Some leaders expressed the progressiveness of their church and ministry regarding mental health. They believed it was best to directly discuss mental health and mental wellness to have a more transparent and authentic discussion. Transparency through communication

would normalize conversations around mental health and seeking assistance in addition to spiritual guidance. In the end, direct conversations were well received by their congregation and community members. Therefore, this form of sensebreaking also served well.

Encourage self-reflection and healing through transparency

As shown in the section above, personal experiences led the leaders to address their own mental health more intentionally, but it also influenced them to be more intentional regarding the messages they shared around mental health. Minister LaKeisha shared how therapy allowed her to become more transparent in her messages within the church. Initially, she was silent about her struggles with mental health. With the help of therapy, she was able to heal and share her story of healing with her congregation. Her messages served as sensebreaking to combat the stigmas against mental health:

> And so once I got into therapy and my healing process began and I finally decided, you know what, I can't continue to put up this front…when I looked in the mirror and I was truly honest with myself, I was able to then say how many more people are walking around…portraying that everything is okay, especially in the church…So, my message shifted because I had to be more transparent. My message came to a point of where I pointed out some of the things that we do when we're struggling, some of the things that we do when we need to be validated and will seek it in whatever way. For me it was like, okay God if you're giving me the opportunity to heal, you're not just doing this for me…it's for somebody else.

As a leader, Minister LaKeisha truly believed that she experienced her own journey to be a voice for the next person who may need liberation or encouragement to start their own

healing journey. Her personal experienced encouraged her to engage in more open communication about her story as well as the importance of mental health in general. After starting her own journey to healing, she became transparent in her communication about the ways society internalizes, stigmatizes, and hides mental health issues. However, with the proper assistance, one can heal from that and lead an overall healthier life for themselves and those around them.

Referrals is a part of sensebreaking

While the leaders are often the go-to for help regarding mental health issues, all of them understood their limits and were comfortable with referring out if need be. The leaders were each clear on where to draw the line personally, but the line shifted with each leader. Some of the women had a set number of visits in which they would provide pastoral counseling before referring out. Rev. Dr. Cereza Luisa stated:

> I can provide up to six weeks of therapy or pastoral counseling before I have to transition them out into either to a certified counselor, therapist recommendation, or what have you. [The recommended timeframe] is based on the church, and you'll find this in most Protestant churches, that as a clergy person you are really not a therapist. You may have a pastoral care or pastoral counseling background. But at the end of the day, you don't necessarily have the licensing unless you're licensed social worker or a licensed therapist.

Some of the leaders did not necessarily set a clear timeframe from their church or educational program. Instead, they learned to create boundaries through their experiences. Some overextended themselves earlier in their career and learned to hone in on their

specific skills and provide resources for instances that were beyond their training. Evangelist VJK shared her learned experiences in shifting boundaries:

> And so, I spent many years being that counselor, unofficially, or having people come to me and me hearing them. And now, I would say in the past maybe five years, I've adopted a new thing. And my thing is, you need to go get counseling…They laugh now because they're like, I know I want to tell you something, and I know I know you're going to say I need to go to counseling…And they know I'm not going past a certain point. Because…I'm not equipped to handle it.

Rev. DeltaRev shared similar sentiments to where she now almost exclusively refers people out:

> I didn't (refer out) during my first 6, 7, 8 years of ministry. Then it got to the point where I said, I can't do all of this…There are some things yes, you can do as pastor of the church, but you can't do everything…I started referring people, and now almost exclusively, out. I'll see a person once or twice and once I get what the issue is, it's like, oh, here's a place to go.

These women were all clear regarding their boundaries as church leaders. They understood their expertise was spiritual care and anything beyond that, they encouraged referrals. These referrals served as sensebreaking in that the action provided an alternate route other than simply "praying about it". The action of referring out communicated to the members that professional assistance is okay, acceptable, and encouraged.

Intentionality when referring out. While all the leaders were comfortable and insistent on referring members to professional resources, many of them were strategic

regarding where they would refer people. Sidney mentions that she is intentional about finding Black resources for her members:

> …I want to make sure that when we are talking about these people that are in crisis, that you are looking at the demographics because a lot of time people of color are left out and do not have access…because they (members) will say 'Sidney, do you know any Black therapists?'…I think it's important that the Black community see there are professionals in that area.

Sidney is adamant about representation for Black people due to access, relatability, and cultural awareness. Minister LaKeisha is also intentional by identifying needs and preferences of the said member that may need to be referred out:

> Well, I have to get certain information and then I can put the feeler out to different colleagues to see who takes their insurance or who has availability if a person is choosing to be self-pay. And then I just give them kind of basic demographic information…dealing with trauma and is looking for an African-American female counselor or an African-American male stuff like that…And where the person needs mental health treatment, we're intentional in our church by not providing services to that person.

Whenever these women refer people out, they take steps to ensure they are making a good referral for the member specifically. While there may be available resources for the leaders to connect to, all resources may not be a good fit. When a resource is not a good fit, it could discourage one from seeking such resources again. Therefore, the leaders implement certain measures in an attempt to make a good recommendation initially.

Rewards in Addressing Mental Health Concerns

As shown above, many challenges came with addressing mental health concerns as a religious leader. Overcoming these challenges came with rewards as well. The rewarding aspects of advocating for mental health served as a great motivator to keep working toward normalization for the leaders. Three major themes emerged as a result.

Reward 1: Changing Perceptions

The first reward expressed by one of the leaders was seeing the perceptions of people really shift toward acceptance. Minister LaKeisha shared her enjoyment in seeing mental health support being normalized:

> I think the most rewarding part is when people realize there's no harm in getting mental health support…a lot of people automatically assume, oh, if I go and I see a therapist and they're going to tell me I have depression or bipolar or schizophrenia. Everything is not going to be schizophrenia, everything is not going to be bipolar, or severe depression, or post-traumatic stress disorder. And even if it is, you can function fine if you get the therapeutic support that you need in the right medication. And you can be an absolute, perfect member of society. I know plenty of people who have mental health disorders, myself being one, who are on medication, they're going to therapy. And that helps to level us keep us balanced.

The challenge of fear leads many to deny their mental health issues or illness because of the unknown. However, with a shift in messaging and support, such as the messages shared by Minister LaKeisha, that fear can decrease. “We all have mental health. We all go through emotional ups and downs. With the proper assistance, we can all be balanced.” Minister LaKeisha has shared this messaged with others to engage in sensebreaking of

dispelling myths and stigmas. In the end, people's perceptions are actually shifting and that is very rewarding.

Reward 2: Seeing People Empowered

The second reward voiced by some leaders is that of actually seeing people go out and physically receive the mental health assistance they need. Pastor Danielle, M. Div., shared a moment where one of her members sought help for grief:

> I think the most rewarding is when people actually get help. We have a grief group here and we had one member who really did not want to do the grief group even though she had a devastating loss. Finally, she got into the grief group and it's like her whole demeanor has changed…now she's like everybody should be in this grief support. So seeing those kinds of transitions, those types of changes in people, very rewarding.

Evangelist VJK shared a similar perspective with the addition of seeing people bridge both the spiritual and physical realm. She expressed that while people still have faith in God, they can still seek out assistance and get tangible resources and help. She stated:

> When people get the help they need and the light bulb comes on and their lives are considerably shifted and they're able to grow and move forward…So, seeing that, seeing faith in God and people utilizing their own agency and not waiting for the Holy Spirit…But seeing people use their own agency that is God-given to move forward and be better, is very rewarding.

Rev. Dr. Grace agreed as she stated:

> My joy comes when I feel people who have struggled, that they are becoming integrated, that these fragments of their identity are coming together and a way

where they feel whole, and they live out of that wholeness and that healing and wellness.

As these women worked through the challenges of addressing mental health concerns, they are able to rejoice with others who come out on the other side. These pastors have seen their congregants and community members receive the help they need. Again, these women have worked through the process of sensebreaking to help others receive assistance in reaching wholeness mentally.

Reward 3: Receiving Appreciation

The third reward is when the leaders receive appreciation for the work they are doing. Many understand how difficult advocating for and working toward destigmatizing a highly stigmatized concept may be. Therefore, when rewarded, the leaders feel like they are doing something right. Rev. Dr. Amy shared an experience where she was surprised with an appreciation:

> So like if somebody just tells me *I appreciate what you did*, or like show me or demonstrates that in some way. So it was my birthday, like two days prior. And then they threw me a little baby sprinkle…I didn't even know, but they said. "hey, we wanted to do this for you because we know that you love to give to us and pour into us and we just want to show that we appreciate you"…and I was just so taken aback.

Rev. Dr. Cereza Luisa shared a similar expression that she enjoys receiving recognition for communicating about mental health issues:

> It's being able to have people come and say, "Wow, you were really talking about mental health issues. And that's not something I've heard before." To me that's a

> great thing. That's a great thing. And then being able to share my testimony, to share my story with my own 40-year journey, just about dealing with someone with mental illness.

These women are constantly engaging in sensebreaking to dismantle the stigma associated with mental health and it is working. Their work has not gone unnoticed. A lot of the leaders have experienced moments of appreciation when members come to just say thank you. These women shared messages that were different, supportive, and normalized mental health and illness and that made a world of difference for some of their members. Many of these messages served as the deciding factor in them [the members] receiving help.

Chapter 5: Discussion

Summary

Black communities are greatly affected by systematic disparities that perpetuate and further create barriers that negatively impact community members' mental health (US National Center of Health Statistics, 2015; APA, 2017). To alleviate these disparities, culturally centered preventative interventions must be developed. Thus, health scholars must place community members at the center of developing the proper information underlying such interventions (Dutta et al., 2019). Further, health scholars need to work alongside community leaders to disseminate health information as those leaders often provide guidance on decision-making. As a religious institution, the discourse within Black churches has been central in the normalization of practices within Black communities. However, regarding mental health specifically, Black churches have aided in perpetuating the stigma around mental health and illness (Cooper & Mitra, 2018). Therefore, Black churches must shift their messaging around mental health and dismantle barriers.

Black church leaders have been integral in providing information and validation for the experiences and decisions of Black community members (Porter, 2018; King, 2009). Therefore, researchers need to examine the communicative practices of leaders within Black churches. Previous studies that have studied leadership within Black churches were heavily consumed with men as participants (Silk, 2002; Hardy 2012). Yet, women have comprised a majority of church congregations and have been the “backbone” of Black churches (Green, 2003; De Leon, 2013). Thus, the voices of Black women, specifically as church leaders, have been muted until recently.

Black Feminist Standpoint served as a unique lens to identify both the theoretical and practical significance of Black women as religious leaders based on their intersecting identities. Due to their identity as both a Black person and a woman, Black women can understand the realities of an insider and an outsider (Collins, 1986). From this social location, Black women can enact a more progressive and well-rounded communication and leadership style. This more progressive form of leadership can be integral in destigmatizing the messages surrounding mental health within Black churches. Thus, it is important to understand Black women's standpoint on mental health.

Weick's (1995) theory of sensemaking was utilized to understand how Black women perceive mental health and how that perception influences the messages they share around mental health. Weick, Sutcliffe, and Obstfeld's (2005) ESR model describes the sensemaking process in three steps. First, the enactment stage is where the event takes place. Second, the selection stage is where one decides how to make sense of that event to determine which path should be taken as a result. Third, the retainment stage is where the chosen result becomes normalized. Paths often reach a stage of normalization through repetitive sensegiving, which occurs when one encourages a particular path to another. Oftentimes, paths that reach normalization are maladaptive as they typically discourage growth. However, leaders can choose an alternative path of sensegiving to promote adaptive sensemaking by encouraging a healthier alternative path. This process is known as sensebreaking.

Through the lens of both Black Feminist Standpoint and sensemaking, this dissertation assessed the current role Black women religious leaders play in discourse normalization surrounding Black mental health. The research questions focused on the

leaders' personal perceptions of as well as the messaged shared around Black mental health. The research questions were:

RQ1: How did Black women come to be in a position of leadership within their church?

RQ2: How do Black women church leaders perceive their position of leadership?

RQ3: How do Black women church leaders perceive mental health?

RQ4: In what ways do Black women church leaders engage in sensegiving with their congregants about mental health?

RQ4a: How has Black women church leader's personal experiences with mental health affect the messages they share with their congregants?

RQ5: In what ways do Black women church leaders engage in sensebreaking around mental health?

The results of this study led to eight thematic categories:

1. Felt a Calling to be a Religious Leader
2. Religious Leadership Exists Outside the Walls of a Church
3. Education on Mental Health
4. Sensemaking of Mental Health
5. Personal Experiences with Mental Health
6. Challenges in Addressing Mental Health Concerns
7. Sensegiving and Sensebreaking regarding Mental Health
8. Rewards in Addressing Mental Health Concerns

Overall, this study adds to theory and previous literature in three main ways. The findings indicate that Black women religious leaders identify mental health as vital to one's overall

wellness, and as a religious leader they play a key role in the discourse around mental health. Further, Black women religious leaders engage in sensebreaking regarding their messages around mental health by destigmatizing mental health and refuting common myths. Their ultimate goal is to promote mental wellness and to normalize seeking professional mental health assistance. The perspectives of these leaders are primarily guided by how they make sense of mental health and how they perceive their role as a leader. A more detailed explanation follows.

Discussion

First, the leaders had a clear stance on the importance of mental health to one's wellbeing. Despite the prevalent stigma, all the women were advocates for destigmatizing mental health and seeking assistance when needed. This finding aligns with Black Feminist Theory (Collins, 1996; 1990) that Black women oppose oppressive systems. The leaders highlighted that barriers such as stigma, associated myths, and lack of access inhibit people within the Black community from seeking the mental health support help they may need, which supports Murry's et al. (2011), Chow's et al. (2003), and Conner's et al. (2010) findings. Further, all the leaders emphasized their mission to shift this narrative and to normalize discussing mental health and seeking assistance. In this instance, the barriers have acted as repressive systems to discourage members from living holistically healthy lives. Thus, the leaders were not only open-minded, but they were active in dismantling the barriers that discouraged people from seeking help.

Findings also support Cooper and Mitra's (2018) findings that the Black church has been complicit in perpetuating mental health stigma, and as a result, there has been a decline in the Black church. Younger community members are finding other forms of

spiritual and religious ministry. This result aligns with Cooper and Mitra's (2018) findings. The leaders highlighted the importance of acknowledging how the Black church has traditionally acted as oppressive by perpetuating silence or relying on praying mental health issues away, and it either needs to be changed or other forms of ministry need to be presented. This could imply that Black women religious leaders understand the experiences of oppression due to their intersecting identities. Those experiences have provided them with an open-minded perspective to other forms of oppression. Thus, Black women's religious leadership may also be a key aspect in addressing the decline of younger adult attendance in Black churches. If young Black adults are finding other forms of ministry due to traditional Black churches' outdated and oppressive teachings, encouraging leadership amongst Black women could be a solution given their proactive perspective. This analysis also guides our attention back to the Black Feminist Theory and how experiences of oppression lead to a more progressive perspective as a leader (Collins, 1996; Parker, 2001). Some of the leaders changed denominations to attain more formal positions of leadership, such as that of a pastor, because their home denomination denied leadership to women. This shift suggests these women were solution-driven in accepting their calling despite systems that were set up to deny them. The women overcame adversity and identified solutions to do the work they were called to do.

Findings could also imply that Black women leaders became open-minded regarding their perceptions of mental health due to their social location as Black women. The instance mentioned above of denominations denying leadership to women forced the leaders to overcome obstacles that were taxing on their personal mental health. Further, Black women navigate society as both an insider and an outsider of marginalized

communities (Collins, 1996). This led Black women to strategically navigate society to overcome multiple layers of hindrances to reach an influential leadership level often presented to communities other than Black women. In other words, society is historically set up so that Black women have often been the last candidate for such positions of leadership and power. These experiences of constant negotiation to appease others are mentally exhausting and could be a driving force in these women's progressive and adaptive mindset. Further, the leaders personally received some level of mental health support when needed. Some of the women sought professional help solely due to feelings of exhaustion, and some felt comfortable because it was normalized in their families, and others were encouraged to manage their mental health from their educational programs. All of them were happy with their decision to seek assistance and reported a life-changing shift in how they made sense of mental health and help-seeking. Overall, the Black women religious leaders presented here are more progressive sense-makers of mental health issues due to their personal experiences.

Second, the leaders engaged in sensegiving in various ways. These findings extend theory around sensemaking, sensegiving, and sensebreaking (Weick, 1995; Gioia & Chittpeddi, 1991, Pratt, 2000). Some leaders shared mental health messages indirectly where they situated the message in the appropriateness of the situation through scripture. For example, some of the leaders promoted the normalization of mental health and illness through scripture narratives when they were preaching. Thus, the sharing of scripture is an appropriate medium of messaging during a sermon. This finding supports Parker's (2001) claim that Black women leaders have a more proactive communication style. Secular messaging alone may not have the same effect from the pulpit as messaging through

scripture. People attend church to receive spiritual guidance through the word of God. As a result, some of the leaders may have chosen scripture as the most effective way to normalize discussing mental health as the narrative in scriptures comes from biblical stories. If members are able to reflect on their own experiences in relation to biblical characters, they may be more inclined to shift their perspectives to align with the messages. Thus, if biblical characters experience mental health issues and can overcome them, we can. While scripture was used as a way to indirectly share mental health messages, it is important to highlight that scripture was not the commonly referred method of sensebreaking. This is interesting given the religious context. However, this could imply that these leaders also understood that in order to engage in sensebreaking and defy the "norm", they needed to also have more concrete conversations.

Other leaders engaged in sensegiving more concretely, which further supports Parker's (2001) conclusion that Black women leaders have a more empowering yet direct communication style. Concrete forms of sensegiving discuss mental health, specifically educational programs, interventions, or conferences focused solely on mental health. Concrete phrases such as "mental health issues", "mental health illness", "therapy/counseling", and "normalizing mental health" were used throughout discussions. These findings suggest that while Black women embrace leadership roles, they still act from a place of care. This could be a result of women traditionally having caretaker roles within the church (Shaw, 2008). On the other hand, Black women could be more outspoken as leaders due to overcoming marginalization experiences. Some of the leaders engaged in sensegiving by sharing their personal testimonies of overcoming mental health issues. These experiences could have led Black women leaders to understand how to

manage sensitive topics. Furthermore, the sharing of one's personal experiences normalizes both the experience as well as the discourse around the experience. Black women leaders may also understand how to empower others by communicating personal experiences. Black women often share messages to support and strengthen one another (Davis, 2015). This exchange of supportive messages could serve as practice for other instances where Black women need to provide support to another.

Also, these findings extend theory on sensegiving and sensebreaking. Literature suggests that sensemaking slows down when one is presented with a situation in which the path to take is not obvious (Weick et al., 2005; Weick, 1995). Further, such ambiguity of indecisiveness often leads people to seek sensegiving from others (Gioia & Chittpeddi, 1991). Findings from the current study also suggest that voluntary sensegiving and sensebreaking can disrupt the automatic process of sensemaking. Thus, when the leaders discuss mental health with members and add professional assistance such as therapy as a viable option, that slows down the thinking process regarding choices around mental health for the members. The members are now provided with a maladaptive (i.e., remaining silent) and adaptive (i.e., going to therapy) option when a mental health concern arises. The addition of the adaptive option causes the member to think more in-depth regarding which option may lead to a healthier outcome. However, in this instance, the slowing down of the sensemaking process would not have occurred without the addition of the more adaptive option. The more adaptive option would not have existed without the leader voluntarily providing that information.

Third, as established in previous literature, Black church leaders often take on the role of counselor for the congregants and community members (Jordan, 2020). This study

corroborates this conclusion as all the leaders had personal experiences where either a church or community member consulted them regarding some mental health concerns—these moments were integral as the leaders primarily engaged in some form of sensebreaking when counseling someone. As the leader's personal experiences were vital in shaping their perceptions of mental health and the messages shared, these stories also served as a form of sensebreaking. When the women shared their personal stories with congregants, they were normalizing vulnerability and discourse around mental health. Silence has often been used within Black churches to deal with mental health (Porter, 2018). Thus, it has been a norm for Black communities to remain silent to avoid the consequences of stigma. These leaders realized the harm in suffering in silence, especially when a healthier alternative is available. Therefore, these leaders engaged in sensebreaking by sharing their own stories and refusing to remain silent, providing a healthier alternative path for congregants.

Further, narratives allow the receiver to apply their personal experiences to the story. Thus, when the leaders share their personal narratives of overcoming mental health challenges, congregants and community members can also envision themselves overcoming such challenges as well. Within these stories, the leaders often shared positive experiences with professional services such as therapists. Black churches have typically shared messages discouraging seeking assistance outside of the church, such as "pray about it" and "God will solve all problems" (Cooper & Mitra, 2018, Porter, 2018). Messages such as that implicitly reinforce mental health stigma and suggest that one's level of religiosity is associated with their mental stability. Sharing stories around seeking professional assistance also serve as a form of sensebreaking in breaking down the stigma

around seeking mental health assistance. Hearing personal stories of mental healing from one's pastor or religious leader provides alternatives to the maladaptive norm of silence and simply praying about it.

The leaders also engaged in sensegiving by referring members to mental health professionals. Porter's (2018) conclusions indicate that leaders are not equipped to handle mental health issues because they do not possess the literacy level necessary for such assistance. This study supports this claim regarding the leaders that attended seminary school. Certain leaders chose to get a more specialized degree where they got more educational training on mental health issues. Still, all leaders understood their limits. Some leaders learned their stopping point in giving pastoral care from their formal education or mentors. These leaders typically had a time frame (e.g., 6 weeks) or a specific set of sessions (e.g., 3 sessions) that they shared with congregants before starting spiritual counseling. Other leaders developed a short timeframe (from 2 sessions to immediately referring out) based on previous experiences, such as overextending themselves in the past. The leaders were adamant about referring out as they were either concerned about being sued for providing care beyond that of spiritual or doing a disservice to themselves and the congregants. Thus, this method of sensegiving also served as sensebreaking in that it emphasized the importance of mental health professionals coordinating and working with church leaders. Referrals contradict the coping method of silence, typically encouraged in Black churches, to promote healing. In the end, the leaders wanted their members to receive adequate assistance. If the member needed care beyond the spiritual realm or for deeper, underlying trauma, they [the member] were almost always referred out. While these findings align with previous studies, this current study adds an important additional

aspect of voicing such limitations during counseling sessions and identifying when members need outside assistance from a specialized counselor.

While Porter's (2018) findings indicated that pastors often remain silent about their own mental health because they feel pressured to take on the problems of their members, the findings of this current dissertation suggest the opposite. The leaders still understood that members felt more comfortable confiding in them. However, this pushed the leaders to be more explicit regarding their personal experiences and the importance of maintaining their own mental wellness. Thus, another conclusion could be that the leaders were insistent on referring members out both so the member can receive proper assistance and so the leader can refrain from experiencing mental exhaustion. One of the ways the leaders addressed this was to be intentional in finding a therapist that was a good fit for each member both in specialization and culturally. Black church leaders have historically been the preferred choice of counseling due to cultural connection and understanding of Black experiences and Black history (Samuel, 2019; Jordan, 2020; Speakes-Lewis et al., 2011). This current study supports this claim and extends it outside of the church as many of the leaders found value in their Black members seeking therapy from Black practitioners. Unless the member already had a practitioner prior to seeking counseling from their religious leader, the leaders provided their members with a list of practitioners the leader thought would be a good fit for them. These lists were often included practitioners whom the leaders knew, had built a relationship with or had a connection/partnership with the church. Some of the churches had in-house therapists. It was through these lists that the leaders were able to identify and advocate for culturally fit practitioners.

Unexpected Finding

One major finding, although unexpected, is that some of the leaders moved their ministry outside of the church. These leaders began providing religious leadership and guidance through other (non-church) organizations. There could be many reasons why this shift is occurring. Cooper and Mitra (2018) highlight that young adults are distancing themselves from traditional Black churches. However, data from the Pew Research Center (2018; 2020) also shows that young Black adults are still religious and believe in God. This unexpected finding could have occurred in relation to these findings. If young adults are transitioning out of Black churches, they may be in search of ministry elsewhere. Thus, some of the leaders may be providing a more non-traditional ministry for such community members. Further, Cooper and Mitra's (2018) findings also indicated that younger members are leaving due to the lack of progression and oppressive teachings within Black churches. Some of the participants in this current study have also experienced this as Black women and queer religious leaders. Therefore, another explanation of this shift is that the leaders want to provide other forms of ministry that align more with their personal beliefs and to be more inclusive. All in all, it appears that ministry outside of the traditional four walls of a church is being normalized.

Practical Implications

To further encourage destigmatization of mental health within the Black community, the following recommendations are suggested. The following recommendations are aimed at the religious leaders specifically, religious institutions, seminary programs, and practitioners.

Discuss mental health directly as a religious leader

The religious leaders in this current study all prioritized discussing the importance of mental health with congregants and community members. The normalization of practices and behaviors starts with community and organizational leaders. Thus, society can become healthier mentally and holistically if leaders start and continue the conversation. There are different ways to start the conversation with congregants. Like the leaders in this study, mental health can be discussed through scripture, sharing personal experiences, or directly through interventions and educational programs. The most important thing is that the conversations are occurring. Congregants and community members will be more likely to accept and address personal mental health concerns if their community leaders discuss and accept those practices.

Encourage Black women leadership

Nearly all of the participants experienced an obstacle embedded within the institution of Black churches that inhibited women from attaining positions of leadership. These practices are sexist and need to be removed and discouraged within Black churches. Further, leadership amongst women should be encouraged. If a woman or young lady is interested in formal leadership, such as ministering, churches should provide her opportunities to achieve such a position. Research supports that Black women leaders provide a much-needed perspective and style of leadership that is beneficial for organizations such as Black churches. Therefore, encouraging Black women to seek leadership positions in the church can propel society more progressively, especially regarding mental health.

Provide at least one mental health course in Seminary and Theological programs

Leaders who received more specialized mental health training felt more prepared, for instance, when members consulted them on such issues. However, many received no formal training on mental health issues during their regular training. Instead, nearly all of these leaders received a specific degree in mental health or voluntarily took additional courses. Other leaders learned only through experience. Knowing religious leaders are often consulted regarding emotional hardships from members, at least one course providing training on handling such issues prior to referring out would be beneficial for both the leaders and the members. Conversely, outside of a course, CPE could allot a certain amount of time to counseling training regarding mental health issues specifically. Ideally, programs could include both a mental course as well as hands-on training.

Connect with Black women religious leaders

It is apparent that congregants and community members often consult their religious leaders on emotionally laden topics instead of practitioners, such as therapists or counselors. With this knowledge, religious leaders can be utilized to promote mental wellness. First, practitioners should work to create educational programs with religious leaders. These programs could be in conjunction with spiritual guidance or be solely about mental health practices. Second, practitioners should build relationships with the religious leaders of organizations near their practices. This study found that all the participants referred members out. Findings also indicated that certain leaders wanted to ensure a good fit between the member and the practitioner prior to referring them. Building relationships with religious leaders can minimize this process and encourage referrals to ensure members receive adequate assistance. Further, being intentional with organizations that are close in proximity can help to bridge the gap in access regarding travel; especially if the

practice is within a neighborhood that does not house many mental health organizations. Third, practitioners can also ensure that religious leaders are handling issues around mental health appropriately. While members are more likely to consult their religious leaders, many of the leaders are not trained to handle such issues. Therefore, programs can also be conducted specifically for the leaders as they will often act as a segue in the members receiving assistance.

As a religious leader, make your mental health a priority

This last and one of the most important recommendations is directed to all religious leaders. Leaders need to take care of themselves mentally. Leaders can quickly become emotionally overwhelmed as they are often the go-to for guidance and who members confide in. Leaders cannot pour from an empty cup. If they do not manage their own mental health, they will be unable to adequately serve as a leader to their congregation and larger community. Thus, if they need assistance, they need to go and get it. Find a therapist. Get medication if needed. Take breaks when necessary. First and foremost, they must take care of themselves before they can take care of others. Secondly, community members follow not only the messages but also the behaviors of leaders. One cannot authentically promote mental health if they do not also practice what they preach.

Limitations and Future Directions

Like all studies, this dissertation is not within its limitations. Three main limitations are lack of diversity in the perceptions of mental health, lack of diversity of religious leaders, and the accuracy of the information provided by the leaders. First, the study captured the perspectives of religious leaders who all believed mental health was important and should be discussed. Future studies should also capture the stories of leaders who have

an opposing view of the findings presented here. It is important to try and capture all experiences and perspectives if possible.

Second, eighteen of the participants were or have been ministers or pastors of churches. One of the participants was a First Lady. The last participant served as both a First Lady and pastor. While this current study did lend itself to a unique and rather limited participant pool, churches have other formal leadership roles, such as deacons. It is important to capture the experiences of all leaders as well as they may have varying experiences and stories. Thus, future studies should also seek to analyze the experiences of other leaders in both formal and informal roles. Ideally, future research should examine the experiences of all the leaders within a religious organization as that would lead us to an accurate and detailed representation of religious leadership.

Third, the accuracy of the recommendation provided by the religious leaders was not corroborated with that of external professionals. Granted, many of the participants did have an educational or professional background in mental health, but not all the leaders did. Therefore, future studies should collect data from both leaders as well as practitioners to determine if the support provided by the leader is appropriate.

Conclusion

Black churches have historically served as central to community building within Black communities. As a result, the communication within Black churches has also been central in the forming the perception of mental health and illness. Historically, Black churches have encouraged a stigmatized perception of mental health and illness by encouraging silence. However, it is time for a change to promote a holistically healthier community. Due to their social location and personal experiences, Black women religious leaders offer a more progressive response to mental health issues in comparison to the traditional practices of Black churches. They view mental health and integral to one's overall wellness and understand that as religious leaders, they are in a prominent position to promote a healthier lifestyle, including that of mental health. As a result, these leaders share sensebreaking messages promoting the importance of mental health with their congregants and community members. Thus, these Black women religious leaders serve as an integral source in dismantling the stigma around mental health and the betterment mental wellness for our communities.

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Appendix A: Interview Protocol

1. Tell me about how you became a minister.
    a. Did you feel a calling?
    b. What education did you get?
    c. Did you get training on handling health or mental health issues?
2. Tell me about how you came to be at this particular church.
    a. What initiated your move to this church?
    b. What made you want to work at this church?
    c. Did it make a difference to you that it was a predominately Black church?
3. What does mental health mean to you?
    a. What comes to your mind when you hear mental health issues?
    b. What about less severe concerns such as stress and anxiety?
    c. What isn't mental health from your perspective?
4. Let's discuss some of your personal experiences with mental health. What are some of your personal experiences with mental health?
    a. Any experiences with mental illness specifically?
    b. How did you cope with those experiences?
    c. Can you share any specific examples?
5. In what ways have those experiences affected how you view mental health?
    a. Is your perception of mental health still the same today?
    b. If not, what made your perception change?

6. Let's transition to your role in handling mental health concerns as a minster in one-on-one settings with church members. Please tell me about a time when one of your church members came to you about a mental health issue.
    a. What was your response?
    b. What advice, if any, did you give them?
    c. Are there situations where members didn't come to you for guidance and you wished they would?
7. Have you ever referred a member to an outside mental health professional (i.e. psychologist or therapist)?
    a. Have you ever felt the need to refer someone but didn't?
    b. If yes, why didn't you refer them?
    c. Please provide an example.
8. Now looking at how you address mental health with your congregation as a whole, could you provide an example of a sermon you gave related to mental health or a meeting where you addressed mental health to a group of people?
    a. What message or advice did you want your congregation to take away from your sermon?
    b. As a minister, have you ever received any pushback regarding your perception of mental health?
    c. If so, please provide an example.
9. As a minister, what is the most challenging part of addressing the mental health concerns of your church members?
    a. What makes is challenging for you?

b. What is the most rewarding part of addressing mental health concerns?

c. What makes it rewarding?

10. Is there anything else you would like to share about your experiences that we have not yet discussed?

    a. If not, why did you decide to be a part of this interview?

Appendix B: Recruitment Letter

Dear Reverend,

I'm writing to request 45 minutes to an hour of your time as a leader of your church. I am currently a fourth-year Black Doctoral candidate at the University of Oklahoma, working on a dissertation on the messages share by Black women leaders within the church concerning mental health and mental illness. We as a community greatly rely on our faith leaders in this area. I would like to interview you via zoom regarding your role and the messages you share to your congregants around this topic. Again, the interview would last approximately 45 minutes to an hour and will be recorded for transcribing purposes. No names or identifying information about your congregants would be asked, and in all reports your name and the name of your church would be changed to a pseudonym.

If you have more questions about the study prior to making a decision, I am happy to provide more information or you can contact the IRB directly, anonymously if you wish at (405) 325-8110. If you feel that you are not the best person in your organization for such an interview, I would be so grateful if you could recommend another who might be appropriate. If you would like to reach me you may respond on here, or my phone number is 254-537-2131 — feel free to phone or text.

Thank you so much for considering my request.

Sincerely,

Tianna L. Cobb

Doctoral Candidate