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## CONTENTS

### SPECIAL ISSUE

- Voices from the Margins: Contemplations on  
Diversity and Christianity in Social Work  
*Kesslyn Brade Stennis & Christa Gilliam* 3–5

### POEM

- Bridging Divides Without Losing Ground  
*Rachel Steele* 6–7

### ARTICLES

- Faith, Family, and Friendship: Experiences of  
African American Women Living in the Margins  
*Jeronda T. Burley & Dawn Thurman* 8–19
- From Education to Transformation: Lessons Learned  
from Teaching in an Urban Community College  
*Man Wai Alice Lun* 20–25
- Mayberry Is Not Our Home: Embracing Danger in  
the City's Public Realm  
*Kevin J. Brown* 26–31
- Family Acceptance and Faith: Understanding the  
Acceptance Processes of Parents of LGBTQ Youth  
*Adam McCormick & Stephen Baldrige* 32–40

Research Advocacy: Afro-Caribbean Immigrant Women Living with HIV <i>Krista Cooper</i>	41–48
Louisiana Black Men at Risk for Prostate Cancer: An Untold Autoethnography <i>Raymond Adams</i>	49–59
<b>POEM</b>	
Who Will Mourn My Black Skin? <i>Franchesca Golson</i>	60–61
<b>REFLECTION</b>	
Reflection by Consulting Editor-in-Chief <i>Helen Wilson Harris</i>	62–64
<b>PUBLICATIONS</b>	65–71

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# Faith, Family, and Friendship: Experiences of African American Women Living in the Margins

*Jeronda T. Burley & Dawn Thurman*

*This article details the personal life experiences and reflections of two African American, Christian, social work educators who identify with multiple marginalized categories and identities. They describe the importance of their friendship and struggles with faith at the intersection of their life stories. Understanding the lived experiences of those living in multiple marginalized groups has implications for Christian social workers as it pertains to social support and coping strategies in the lives of those living in the margins.*

MUCH HAS BEEN WRITTEN IN THE PROFESSIONAL LITERATURE about the marginalization of certain groups of people who self-identify as African American women (Jones & Guy-Sheftall, 2015), Christians (Van Camp, Sloan, & Elbassiouny, 2014), and individuals with chronic diseases or their caregivers (Carlisle, 2014). Research suggests that members of these groups tend to cope using a variety of techniques that involve faith, family, and friends (Crowley & Curenton, 2011; Holt, Roth, Huang, Park, & Clark, 2017); however, the literature on coping strategies of those who conceptualize themselves in multiple marginalized groups is scant. Even less is known about the coping strategies of women who self-identify as African Americans, Christians, mothers of medically fragile children, cancer-survivors, amputees, and social work educators. This article shares the stories of two women who identify in the aforementioned categories. They share their experiences as teachers, the trials that challenged their faith, and the triumphs over the tensions of their faith.

## **Our Experience**

### **Dawn's Story**

As a child, I envisioned myself married with three children by the age of 30. Because no one in my upstate New York family had attended college, the thought of attending never occurred to me until my sophomore year in high school when I met a 24-year-old African American female counselor who had obtained her master's degree. Our interaction influenced my vision for myself. I realized that I could do and be anything that I wanted. While I still had the strong desire for marriage and children, I also kept going to school all the way from pre-K to Ph.D. My personal goal was to obtain the master's degree just like my role model, but I was encouraged to apply to a Ph.D. program by others who recognized my potential as a future academician and researcher. I entered the program hesitantly, learned a lot about myself and the profession, gained life-long relationships along the way, worked to gain additional clinical experience and, after six years, I earned my Ph.D. degree and was "ready" for life!

### **Jeronda's Story**

I am a Southern girl from Alabama, the oldest child (by 16 years) of three siblings, and the daughter of a mom and two dads - one who was responsible for my conception and birth and the other (my stepfather) who was most responsible for my development. I never referred to my stepfather as "step;" he was just "dad." As a goal-oriented and fiercely independent child, by age 14, I was surprisingly clear about my life goals to pledge Delta Sigma Theta Sorority, Incorporated, to earn a Ph.D., and then to get married. As the product of a mother who was in the same sorority, Delta Sigma Theta, and a daughter of parents and other family members who were educators, obtaining higher education was a foregone conclusion to me. Once introduced to the concept of becoming a "doctor," I knew that I wanted that as well. Interestingly, at that age, marriage seemed like the next logical step, but having children was definitely not logical or desired, at that time. So, with my trajectory clear, I graduated from high school, completed my undergraduate degree and two master's degrees, pledged Delta Sigma Theta Sorority, got married (out of order, but in love), then earned my Ph.D. Oh, and along the way, I attended seminary and later became a licensed minister. I felt "ready" to fly.

## **The Teacher**

### **Dawn**

Immediately after completing my doctoral degree, I resumed clinical practice. After serving as an adjunct professor for two years, I was offered a Visiting Professor position and absolutely loved it! It was a perfect opportunity

to share my clinical experience with emerging professionals. While at the university, I had a divinely orchestrated appointment with another first-time, full-time contracting professor named Dr. Jeronda Burley. Having a shared office facilitated our ability to support one another as junior faculty traversing through the strange land called “the academy” and as young married women who were trying to find the seemingly elusive “work-life balance.” Among other things, our conversations spanned many topics, including simultaneous professional goal attainment for academic permanency and personal goal attainment to expand our families.

### **Jeronda**

Although I had no plans or desires to become a teacher, I guess it was in my blood. When I concluded my doctoral program, my goal was to become a researcher, but a chance encounter led me to academia, first at the junior college level and six years later to a full-time assistant professor position. In our dark, windowless and cold-shared office, I bonded with my office mate, Dr. Dawn Thurman. We shared many similarities: African American women, relatively young academicians, graduates from the same HBCU (Historically Black Colleges and Universities), and young wives pondering the possibility of family expansion. Dawn and I also shared many laughs, dreams, and strategies in that office, even those related to how and when to get pregnant. Since Dawn was already a mother of one child, I appreciated her tips.

Imagine our supervisor’s shock when we both announced that we were pregnant during the second semester at the university and that our due dates were two months apart! Our shared office soon became our “power nap” station. Both Dawn and I tried to stay awake during meetings, and I tried not to vomit during classes.

### **Dawn**

Everything seemed “normal” until four weeks after learning about my pregnancy when I also learned that I had breast cancer. While attending a routine OB/GYN appointment, my doctor asked if I had concerns about the density of my right breast. I shared that I had none, but that I had noticed an occasional sharp pain. Since she knew that my husband and I were attempting to get pregnant, she ordered a mammogram to rule out any concerns. The results came back with minor abnormalities. I was then sent to get an ultrasound. After undergoing a painful and scary series of sonograms that took over three hours and included a few biopsies, I became worried that something was wrong. The tech assured me that someone would be in contact with me regarding the results, so I waited. On a Thursday night, well after 9:00 PM, I received a call from the radiologist informing me, emphatically, that I had breast cancer.

The diagnosis and the days that followed without answers to explain my type, stage, aggressiveness of cancer, and best course of treatment threatened my faith, vision, future, peace, feelings, stability and, most importantly, my family. I recall looking at my one-year-old son, remembering that I was nine weeks pregnant with my second child and then crying aloud, "I don't want to die!" At ten weeks of pregnancy, I learned that I had Stage 1 Infiltrating Ductal Carcinoma (estrogen and progesterone positive), which was a challenge for me, my family and my medical team. After several consultations with experts around the country who specialize in treating pregnant women with breast cancer, it was decided that I would undergo a unilateral mastectomy in my second trimester and begin four rounds of chemotherapy after recovering from surgery.

After the decision was made, I found myself trying to balance my faith with my fear. Even though the "prayer warriors" in my circle believed that I would be healed without the aid of chemotherapy, and even though I quoted inspirational sayings and played gospel music to buoy me, I questioned if God would heal me and save my unborn child. The fear, depression, embarrassment, shame, and humiliation were overwhelming. The outside world was none the wiser. Family, friends, co-workers, and even my doctors praised me for maintaining a positive attitude and optimistic outlook on my circumstance. Many would say that my strength was inspirational, but I frequently found myself feeling guilty because I did not allow those close to me to know my inner thoughts and deep sadness. My fears were magnified when I realized I would not have reconstructive surgery at the time of the mastectomy because extended exposure to anesthesia would compromise my unborn child and me. This made me fearful and self-conscious to live my life as an amputee for well over a year. In addition, knowing that my hair would fall out made me question my existence and identity as a woman, wife, and mother. I felt punished by God.

### **Jeronda**

Being pregnant sucked. The sickness was almost debilitating. I had daily pity parties, until the day Dawn told me about the pending mammogram. To me, she did not seem worried at all, which was completely baffling. There is no way I would have been able to continue working as she did, and with such excellence, knowing the journey that lie ahead. I secretly admired Dawn's strength, but I prayed fervently. While I was shocked by the breast cancer diagnosis and gravely concerned about the process she would undergo, I refused to waver in my faith that God would heal her, with or without medical intervention, and would protect her baby. My fight to maintain control of my bodily fluids paled in comparison to Dawn's fight to maintain her life.

My pity party ended the 21<sup>st</sup> week of my pregnancy when my husband rushed me to the hospital for preterm labor. I can still vividly see myself in

the hospital elevator telling my husband to text Dawn to ask her to inform my students that I would not make it to class that day and to let the director know I was in the hospital. After contacting Dawn, I contacted my inner circle of friends and asked them to pray. I was terrified and thought I was losing my baby. Finally, they were able to stop the contractions. Then I was mandated to remain on bedrest for three weeks. While thankful that my mom and mother-in-law arrived to assist me so that my husband could return to work, I was also humiliated that they, and my friends like Dawn who came to visit several times a week with her beautifully bald and scarfed head, had to manage my activities of daily living.

The one who had ministered to so many was now being ministered to. The feelings of discomfort and vulnerability during those almost three weeks morphed into feelings of helplessness, depression and even suicidal ideations after our little miracle was born at 24 weeks of pregnancy weighing less than a pound. From the time the neonatologist made 12 attempts to intubate her to assist with breathing, through the six and a half months she spent in the Neo-natal Intensive Care Unit (NICU), my faith wavered almost to the point of no return. The enormous pressure from preterm delivery, life in the NICU, care for a medically-fragile baby, isolation from friends, non-existent ministerial presence from my church, marital strain, mounting financial burdens, and constant fights with insurance companies due to my own pre-existing condition that I was not even aware of, took a toll on me. No Christian colloquialisms or scriptures could mend these wounds. I prayed that God would heal my baby and make it all okay again, but the once fiercely independent, focused and faithful woman that I identified myself as, felt abandoned by God. I felt like Job.

### **Dawn**

It was only by the grace of God through prayer, faith, and the support of dear friends like Jeronda that my baby and I survived cancer. Along with having an amazing spouse who was completely devoted to me during this time, I was also supported by family members and friends who came from near and far to take care of my one-year-old son and other needs as they arose. In many ways, they filled in the emotional and spiritual gap when I felt extremely disconnected from, and disappointed by, my church that was relatively absent during this most vulnerable time. Although my church was absent, Jeronda was present. She was one of my closest, most consistent and selfless supporters while in recovery. Even though she was on bedrest and her own “miracle” was in the NICU, she visited me, prayed for me, and spent many moments showering me with her contagious faith in God and positive energy. This hope comforted my soul and assured me that everything would be okay, and it was.

### **Jeronda**

After a lengthy six-and-a-half month, lonely journey, our precious miracle was discharged home. The next few years would include numerous hospital admissions and repeated setbacks. Nevertheless, we were thankful to have our baby home. The doctors said she would not live. They gave us very little hope. Thankfully, we put our hope and trust in God alone. I eventually resumed contact with friends. Returning to church was extremely difficult. I had only attended worship services online. I tried going to an actual service, but seeing other babies with their parents was unbearable, particularly knowing that my sweet girl was in the NICU fighting for her life. I resumed my online worship services. Several months later, the many conversations with Dawn helped put life in perspective. I was amazed by her strength, especially in the middle of her own fierce storm. Every time I saw Dawn, she had a smile on her face. It was contagious! I thanked God for her often and continued fervent prayers for her full recovery.

### **Discussion**

This special edition has allowed us to reflect on the past six years of our lives from a personal and professional vantage point. On a personal note, we have maintained a relationship that is highly valued. The simultaneous challenges that forced us to re-evaluate our identities as African Americans, Christians, mothers of medically fragile children, cancer survivors, amputees, and social work educators have drawn our families together in a manner that is almost inexplicable. We intentionally make sure that our miracle daughters spend time together at playdates and birthday parties. While they may be too young to understand the depth of their mothers' bond, we pray that, in time, they will appreciate that their divinely unique relationship was knit while "in utero"- in that small, dark, cold office space. Faith and their mothers' friendship have bound them together as family for life.

As we reflect on the concurrent challenges from our professional paradigm as social work educators and researchers, we can validate that the social support from faith, family, and friends were the key components of our coping strategies though experiencing multiple marginalizations (Chatters, Taylor, Woodward, & Nicklett, 2015; Crowley & Curenton, 2011; Holt, Roth, Huang, Park, & Clark, 2017; Nguyen, Taylor, & Chatters, 2016; Sheridan, Burley, Hendricks, & Rose, 2014). However, the more traditionally accessed support system for African American people of faith, the Black church, seemed less accessible and effective in supporting us. For example, Jeronda spent an entire year of Sundays in a hospital room at her daughter's bedside. Thankfully, technology utilized by her church allowed Jeronda to "virtually" attend most Sunday and midweek services. Undoubtedly, this

online access to worship services sustained her faith and enhanced her spiritual connection with God. However, it cannot be denied that the level of connectedness and social support that typically occurs within face-to-face worship settings were diminished, which contributed to feelings of isolation and resentment. Fortunately, informal supports such as workplace relationships, friends, and family were inextricably connected to our faith. Processing the pain was difficult, particularly given the limited tangible support from our church family. Recognizably, our emotional distress impeded honest discussions about frustrations with family and friends during this difficult season of life. After her diagnosis, Dawn disassociated herself from extended family whom she felt anger towards for not caring about her well-being before her diagnosis. She erected an invisible wall to protect her from feeling pitied and weak.

This was particularly true for Jeronda, who had expected occasional NICU visits from friends and ministerial staff from her church where she was actively involved. It did not happen. They were absent, and the women were furious. In fact, nearly all Jeronda's visits ceased immediately following her daughter's preterm birth. Dawn and Jeronda both experienced grief from not having a normal pregnancy. They could not ignore feelings of guilt over feeling as if they should have been able to do something more to prevent the situations. Dawn and Jeronda tried to dispel self-directed anger over not being more honest about their needs and God-directed anger for allowing these extreme stressors to occur.

Notably, this experiential narrative was not pinned to disparage the Black church. Rather, after some time to process our pain, we now recognize that the values espoused and taught by the church, such as faith, prayer and the importance of family, were operationalized in a manner that sustained us spiritually, emotionally, and psychologically. Messages surrounding love for thy neighbor, care for family, reliance on faith in God, and involvement in community, affirmed principles taught by the Black church. These messages were demonstrated through our friendship and undoubtedly helped us to cope more effectively with strains surrounding our multiple marginalized categorizations (e.g. African American, a woman, Christian, non-tenured junior faculty, mother of medically fragile child, cancer-survivor, and amputee). Such effective coping is validation and expansion of the findings from other scholars about the impact of the Black church (Chatters et al., 2015; Lincoln & Mamiya, 1990; Nguyen, Taylor, & Chatters, 2016). Dawn's breast cancer diagnosis and the health crisis of Jeronda's daughter resulted in significant emotional stress, which further intensified feelings of marginalization. While neither was diagnosed with depression, their mental health was understandably and undoubtedly compromised. Nevertheless, they held fast to their belief in God and remained confident in Biblical promises, which they rehearsed to themselves often. Dawn and

Jeronda were surrounded by people of faith from their churches, family, friend circles, and communities. These unwavering supports proved to be what the Bible refers to as a “Balm in Gilead.” While these social support networks were influenced in part by the Black church, their healing effects spanned well beyond the confines of the church walls. Dawn’s and Jeronda’s experiences of “faith-full” support was not unique. Seminal research has affirmed that for decades, as the bedrock of the African American community, the Black church has traditionally been the initial and most viable mechanism of social support for those experiencing marginalization and distress (Billingsley, 1999; Lincoln & Mamiya, 1990; Taylor & Chatters, 1988). Recent studies have explored this church-based social support and its impact on outcomes such as coping, stressors, physical health, depression, and others (Chatters, Taylor, Woodward, & Nicklett, 2015; Crowley & Curenton, 2011; Holt, Roth, Huang, Park, & Clark, 2017; Roth, Usher, Clark, & Holt, 2016). These findings have consistently revealed improved health outcomes for African Americans who maintain some connectedness to a faith community and/or embrace spiritual practices to supplement their religious involvement. An investigation conducted by Roth, Usher, Clark, and Holt (2016) found and corroborated previous research that religious involvement (personal and organized) was linked to improved health outcomes for African Americans. Further, the authors asserted that religious beliefs had a more significant impact on mental and physical health than mere church attendance. Such findings validate the shared experiences of Dawn and Jeronda. Although circumstances limited their organized religious involvement (physically attending Sunday worship and other on-site church activities), both maintained their personal religious beliefs and spiritual practices, which sustained their faith and ultimately their mental and physical health in the midst of coping with various marginalizations.

### **Marginalization and Recommendations**

This section discusses recommendations on how social workers and the Black church might address issues of multiple identities and marginalizations. This is important for medical social workers and, in fact, social workers in all contexts.

#### **Marginalization and Recommendations for Social Workers**

Based on our collective experiences of marginalization, we considered the following recommendations for social workers. During conversations with NICU moms after her daughter’s discharge, Jeronda discovered that the medical social worker failed to offer significant resources to her family such as parking vouchers, a mortgage support program, cafeteria vouchers,

temporary housing, and others. Assumptions should not be made about family needs and abilities. It is critical that social workers be fair and equitable in distributing information and resources to the clients they serve. Medical social workers are trained in taking universal precautions. Similarly, there is an opportunity for them to offer universal resources to all families receiving extended hospital care. As fellow social workers, we believe that their lack of equivalence in advocacy for families appeared to be unethical. The burden should not be on the families to ask for assistance that is available to all.

There were several missed opportunities for social workers to connect and offer additional resources. As an example, discharging from multiple procedures (i.e., surgery and chemotherapy) could have included planning access to community-based resources and national organizations targeted to support breast cancer survivors. As Dawn sought financial and social support from national breast cancer organizations, she encountered a tremendous amount of red tape, which made it impossible to navigate given her reduced energy level during pregnancy and while receiving chemotherapy. Dawn waited more than a year before undergoing reconstructive surgery due to a change in her medical insurance and increased out-of-pocket payment requirement. Having a social work case manager might have been helpful in expediting the procedure considering the millions of dollars donated to various national breast cancer organizations to support breast cancer survivors. Dawn felt marginalized because she knew resources were available for women in her same medical predicament, but she was unable to access it for herself. Dawn believed she experienced marginalization because of having an extended support network. Perhaps social workers made assumptions about her financial resources or access to services, as well as her educational level and ability to seek and obtain services. Either way, she was left feeling as though she alone had to navigate seemingly impenetrable systems. Resulting was the awareness that marginalization exists even among highly educated and trained social work professionals with an extended support network.

### **Marginalization and Recommendations for the Black Church**

As highlighted throughout our story, there were conflicts of faith we had to overcome. Tensions emerged due to the responsiveness (direct and indirect) from our church communities. This marginalization by the church seemed to challenge the depth of our faith whenever we expressed fear, anger, vulnerability, anxiety or depression. Directives to “just pray about it” and “put the Word on it” felt offensive in that it seemed to presume we had not been praying effectively or enough, and that our faith in God’s promises (the Word) must be lacking. Comments such as “take your worries to the altar and leave them there” caused even further marginalization and failed

to acknowledge the connection and support we longed for from our church community. Unfortunately, discussions about mental health in the Black church are often non-existent or limited at best, which prevents needed access and sustains the pervading mental health stigma among African Americans.

Notably, our intention is not to demonize the church, nor are we suggesting the church was unhelpful during our greatest time of need. As women of faith, we recognize the value of the church and wholeheartedly believe in the power of prayer. However, our own experiences with life-threatening illness, caregiving, depression, marital strain, financial duress, medically frail children, and extended hospital stays have qualified us to offer recommendations for church leadership and congregations. Firstly, altar call follow-up is essential. Most Black churches have an altar call at some point during the worship service. During this time, when a person comes forward for prayer or shares a pressing concern, it is critical to have a minister follow-up, to not only say hello, but also to readily provide appropriate referral information if additional follow-up is needed. Secondly, many churches should expand their responsiveness to those with health issues. Most congregations have a “sick and shut in” section in their church bulletin. In addition to praying for these persons, churches might also include meal delivery services to those who are “sick and shut in,” as well as to their caregiver(s). Clergy must also remember those with extended hospital stays, including the patient and the often forgotten caregiver who remains at the hospital bedside or manages life at home and the hospital. Thirdly, churches with a media ministry could deliver CDs or DVDs of sermons so that members can remain spiritually connected and fed during times of extensive isolation due to sickness or disease. Fourthly, it is imperative to have recurring sensitivity training for church leaders and various ministries on the most appropriate language to use when communicating with those who are in distress. Framing every hardship as an opportunity for a “testimony” diminishes the pain one currently feels and impedes the desired connection with their church family. A document on “what to say and what not to say” to people in crisis could be an effective training tool. Lastly, mental health providers are often members of the Black church community. Congregational leadership should utilize their professional knowledge and expertise to help create an environment that promotes mental wellness. Acknowledging the history of the Black church’s relationship with help-seeking behaviors due to mental illness is a critical step. Undoubtedly, the pastor is key to dispelling mental health stigma. When dialog is initiated from the pulpit, church members will discontinue marginalizing one another when “praying about it” is not enough. Reminding congregants that God is omnipresent (everywhere) and omniscient (all-knowing) could assist the church in cultivating a safe environment that welcomes honest conversations about depression, suicide, and trauma. Once conversations begin, churches must be equipped with outsource referrals for individuals and families to get

the help they need, if there are no clinically licensed mental health providers on staff. These are merely a few recommendations to mitigate the effects of marginalization by the Black church.

### Conclusion

The faith-filled stories described in this narrative piece validate existing research on marginalization, multiple identities, and coping mechanisms (Chatters, Taylor, Woodward, & Nicklett, 2015; Hayward & Krause, 2015; Sheridan, Burley, Hendricks, & Rose, 2014). Previous research suggests that exposure to multi-layers of oppression (race, gender, Christianity, chronic diseases, etc.) impede the coping process (Carlisle, 2014; Jones & Guy-Sheftall, 2015; Van Camp, Sloan, & Elbassiouny, 2014); however, religion and spirituality are effectively utilized by African American women (Boyd-Franklin, 2010). Studies have shown that, coupled with social support received from friends and family, African American women can transcend the effects of marginalization (Crowley & Curenton, 2011; Holt, Roth, Huang, Park, & Clark, 2017). Dawn and Jeronda found this to be partially true. While they eventually transcended the effects of marginalization, this process did not occur immediately. Over time, they reflected on their experiences, which revealed a deeper insight into the integration of faith, family, and friends to buffer the impact of marginalization. Dawn's and Jeronda's experiences substantiated the belief that support systems may not be enough to fully counter the power of marginalization by the profession and the Black church. ❖

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