LIBERTY UNIVERITY SCHOOL OF DIVINITY

AN ANALYSIS OF CAUSES AND IMPACTS OF DEPRESSION IN PASTORS

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by

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A STRATEGIC PLAN TO DEVELOP A HEALTHY CHURCH

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ABSTRACT

Depression is becoming more common among pastors because of the stress and strains of ministry, as well as other personal issues. Therefore, this analysis looks into how different mechanisms such as social support and traditional religious values tend to function across different groups of the religious community. The purpose of this study is to understand the issues that would cause a pastor to become depressed and also to devise a plan of action that will provide alternatives to dealing with depression in a positive and healthy manner. This analysis will expand on existing literature and reports that argue on both primary and in-depth belief systems that affect members of the clergy in different religious groups. Religious traditions of the Jewish, Catholic and Protestant have been considered for the study.

Keywords: depression, suicide, mental illness

Abstract Length: 129 words

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Abbreviations

CCN	Christian Care Network
Ch	Chapter
Cor	Corinthians
Num	Numbers
Ps	Psalms

CHAPTER 1

INTRODUCTION

Mental illness is becoming a major health issue that is affecting individuals at an alarming rate. According to the National Association for Mental Health, in the United States alone, over 60 million Americans can be diagnosed yearly as having one or more of the 200 categories classified under the heading of mental illness.[1] The disease is an illness of the brain that ranges from mild to severe interruptions of thought and behavioral patterns, consequently, resulting in a lack of coping ability when facing life's general demands and ordinary daily routines.

One major category of mental illness is in the form of depression which is defined as a feeling of severe sadness and dejection. The signs of depression include depressed mood, loss of interest or pleasure, low-self-esteem, a feeling of guilt, interrupted sleep patterns or appetite and concentration problems. This condition occurs as a result of negative life events such as the loss of a significant person, relationship or health issues, but has a possibility of occurring for no apparent reason. Depression is not selective in whom it resides and, if left untreated, can have a catastrophic effect. Suicide, which is an act of ending one's life voluntarily, can be the ultimate price for failing to seek treatment. Depression is definitely a serious health issue that must be recognized and addressed.

Significant advancements have been made in religious doctrines that have contributed to the expansion of knowledge based on the suicidal behavior of depressed pastors. Depression is one of the most common mental illnesses in America, yet this health issue as it relates to pastors has been ignored by the church for many decades. Further, a substantial

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[1] National Alliance on Mental Illness (NAMI) Mental Illness Facts and Figures, wwww.nami.org, Retrieved September 15, 2015.

amount of information pertaining to suicidal attempts among members of the clergy exists, still, suicidal depression remains misunderstood in the church.

Mental illness is not only a health issue with the general population, but with pastors and religious leaders, as well. The writer of this thesis began to finally understand the gravity of depression after the suicide of his closest friend in 2014. This 42 year old friend, who was also a pastor, left behind a wife, two young children, and a thriving congregation who never knew the depth of his depression. This friend had confided in the writer two years earlier his personal battle with depression but refused to reveal it to his own congregation for fear of being judged or losing his church.

After the death of his friend, the writer, who serves as pastor of an African American congregation in Southwest Georgia, fully acknowledged the stress of pastoring and began to deal with his own issues. Prior to the death of his friend, the writer believed he could identify depression in his parishioners and address it, but had a tendency to ignore or suppress his own level of stress as related to his pastoral duties and his personal life. The writer had learned to ignore the signs of depression in his own life after years of observing "older" pastors who believed that if they took care of their flocks, God would take care of them. In his early years in the ministry, the writer believed that a pastor should not share his personal life. After the death of his friend, though, the writer made the conscious decision to become more transparent with his congregation regarding his struggles in order to develop a healthier lifestyle.

Primarily because of the suicide of his friend and his own personal experience with stress brought on by a combination of personal and ministerial duties that sometimes seem overwhelming, the writer chose to research the topic of depression and suicide to become more knowledgeable about the subject. The writer also aspires to give pastors and religious leaders a viable source for identifying and understanding the signs, symptoms and causes of depression and ways to effectively address the issue.

Statement of the Problem

The position of a pastor can be a high-profile and stressful job with sometimes impossible expectations from the followers and the community. The congregation unrealistically expects the pastor to be available twenty-four hours a day, seven days a week to help solve their problems. Expecting pastors to forget their mortal nature can breed loneliness and isolation. According to Greg Warner (2009), suicide among pastors can be attributed to a lack of social support when they are going through personal crises.[2] In addition to the congregation and family expectations, pastors themselves often impose unrealistic demands on their own lives; and when they fail to achieve these demands they may become depressed and feel hopeless and frustrated. Ultimately, the pressure to please may lead to stress and depression.

Pastors often counsel other people regarding their issues but do not follow helpful means in dealing with their own internal issues. They try to be all things to all people and as a result, they lose a sense of self. Pastors may fear being looked upon as unspiritual or unaccommodating if they are not accessible to address the individual concerns of the church members. Parishioners assume that pastors have a more direct contact and closer relationship with the Lord than the layperson, therefore, pastors are not supposed to have problems. As a result, pastors do not share their difficulties for fear of rejection or being seen as a failure. What do pastors do, then, when they are struggling with personal issues?

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[2]Greg Warner, "When depression leads pastors to suicide," *The Christian Century* 24 (2009): 14.

Statement of Limitations

Mental illness has been viewed negatively, in general, but especially in the African American religious community, as perceived by this researcher. Depression and suicide is a very sensitive subject that could limit the participation of pastors who often mask their own feelings for fear of being judged or condemned as not being as close to God as they represent. Many pastors declined to be interviewed or would not return the interview questionnaire. Further, some of the pastors viewed depression and thoughts of suicide as a private issue and chose not to participate in the study. A limitation to the study could also be the differing beliefs about depression and suicide within the same religious groups as it relates to where persons who commits suicide will spend their eternal lives. Finally, the use of one church could be a limitation because the survey and questionnaires will be from one population who was faced with the reality of depression and suicide following the self-inflicted death of their own pastor.

Theoretical Basis

Pastors and church congregations from various religious affiliations sometimes have different expectations of pastors. Many church congregations expect the pastor to always be available for their various needs such as counseling, weddings, hospital visits, bereavement and countless church activities and worship services. Many members of the congregation fail to realize that pastors have their own various issues. They believe that pastors should be able to more effectively manage their issues since they have a calling from God to the pastorate. Because of this belief, many pastors fear losing their position of authority if they are transparent with their own personal battles; therefore, they suppress or mask any mental illness with which they may be dealing. Some pastors even feel that simply praying to God will deliver them from their mental condition instead of seeking professional help. This behavior has led some religious leaders to moral failures or even suicide.

Today pastors must find a balance between helping others in dealing with their

varying needs and finding a healthy way to deal with their own personal needs without feeling that they are abandoning their parishioner or failing God while taking care of themselves. In order for pastors to get to a place of health, they must take practical steps in doing so.

In biblical days, the word "depression" was not used; however there are Scriptures that reference individuals being depressed. In 1 Kings 19, when Elijah heard Jezebel's death threat towards him, he fled for his life and wanted to die. In Psalm 34:17, the righteous cry out for God to deliver them from their troubles. This is a concept of the righteous that endures troubles. Romans 8:38-39 speaks of letting nothing separate us from the love of God. These Scriptures are often used to encourage others when dealing with depression.

The Bible mentions several instances of suicide but it does not give specific teaching about the subject. In Judges 16:29-30, Samson committed suicide while fighting with the Philistines. Judas, in Matthew 27:25, was depressed after having betrayed Jesus; as a result, he hung himself. Though, these instances of suicide were recorded in the Bible, there is no particular Scripture that speaks directly to what happens to a person's soul as it relates to eternity. Because of the lack of direct biblical references, many religious doctrines have their own interpretations as it relates to suicide and where a person will spend eternity.

Due to the alarming rate of pastors who are leaving the ministry because of the stress of pastoring that sometimes lead to depression or even suicide, pastors must take a different approach when it comes to dealing with their own personal health. They must understand that admitting that they need help does not make them less spiritual. Pastors must come to the realization that they are not invincible and they have limits, just as other people do. Increasingly, pastors are searching for how to effectively minister to others while not losing themselves.

Religion is an important part of everyday life, however, most religious beliefs and practices vary widely depending on the initial tendencies of specific cultural groups. Despite

some of these differences, there is substantial evidence to suggest that certain beliefs or obsolete routines in religious practices often serve as a leading cause of mental illness among the spiritual leaders of those groups. These studies mostly reveal that there are specific practices that tend to help members of the clergy cope with the full weight of stress often encountered in the profession. Related data confirmed that almost sixty-one percent of the case studies involved during research resulted in negative outcomes, whereas only six percent yielded a positive relationship.[3] Similarly, these reports also showed that there may not be enough evidence documenting the likelihood of an inverse relationship between religious spirituality and suicide. The lack of inverse relationships in the matter of study posed a significant challenge during data collection.

A significant portion of published works that focuses on the general relationship between suicide and religious depression dwells on the idea of belief in the afterlife. These research materials suggest that a belief in an afterlife, where present actions in this life will be judged, may be a protective measure against suicide among depressed pastors. However, research materials could not help determine the levels of belief in each documented Christian community. This information would have proved useful in determining which groups were most likely to resort to more extreme religious practices. Stack's research revealed that countries with relatively higher levels of religious commitment reported lower rates of suicidal deaths among depressed pastors.[4]

3Paul Tripp, "The depressed pastor: the setup" Christianity, 2015.

[4] S. Stack, and I. Wasserman. "The effect of religion on suicide ideology: Analysis of the networks perspective." *Journal for the Scientific Study of Religion, no.* 31(1992): 457-466.

Similarly, Stoppelbein and Greening (2002) uncovered that there is a significant level of correlation between the degree of commitment to pre-acquired religious beliefs and suicidal risk. According to their research, doctrinal orthodoxy is mostly to blame for suicidal attempts, whereas, intrinsic religiosity based on internalized religious assumptions led to an increase in depressive symptoms and suicidal thoughts.[5]

There was some degree of challenge in acquiring symptomatic reports from research sources. For instance, it is common belief that normal signs of depression may include severe, impairing and lethal thoughts that may lead to potentially harmful physical actions. However, some of Lawson's research (1999) indicates that there may be some factors pertaining to risk and communal protection, suicidal thoughts and suicidal actions that are not uniform across all regions.[6] Therefore, efforts are needed to merge Christians' understanding of the potential dangers of underlying religious tendencies and suicidal outcomes.

Based on a study performed on religious practitioners in the Buddhist religious community, researchers uncovered the need to firmly establish the relationship between religion and suicidal tendencies. In 2000, a study was undertaken to unravel the journey to salvation as portrayed by Buddhists. The split that exists between the Mahayana and the Theravada Buddhist communities acted as the main avenue for which studies can reveal the relationship between an individual's progress on a religious path and behavioral outcome.[7]

Researchers found that the Mahayana Buddhist religious enlightenment mainly insisted on redemption through the salvation of others, whereas the Theravada believed more in personal salvation. These differences were not only seen to impact the entire society's

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[5]L. Greening and L. Stoppelbein, L. *Religiosity, attributional style, and social support as the psychological buffers for African American and white adolescents' perceived risk for suicide,* Suicide and Life Threatening Behavior, 2002,:404-417.

[6] Lawson et. al. "A systematic review of the mortality of depression." *Psychosomatic Medicine*, no. 61 (1999): 6-17.

[7]Ibid.

attitude towards the religious community, but also revealed what factors determine each group's understanding of ultimate reality. Their different beliefs sparked various reactions from the entire society, thereby rendering different levels of collaborations towards the overall well-being of religious practitioners suffering from depression and stress. For example, the immediate community of religious practitioners on the Mahayana Buddhist community received relatively more social support in comparison to the Theravada community. This pointed out the fact that the society is more likely to embrace treatment from those willing to embrace communalism in return. While this may have been perceived by most as selfishness, the reality is that social support is entirely dependent on the relationship between unity and religion.

The study above showed that the belief in communism is a strong mediator between suicidal tendencies and religious beliefs. However, social support may have other relatively important mechanisms that may require significant research. In this context, social support is seen as a broad and somewhat complex construct that could be measured differently across all the religious groups and denominations. The study paid attention to communal social support only, but it may have ignored an important consideration based on the communal support received from family members and close friends.[8]

There is a possibility that the amount of support given to religious practitioners from different sources may differ across other religions. For example, the Hinduism society has been shown to place great emphasis on the importance of family support. As a result, researchers believe that this kind of link may mediate the need for suicidal behavior among religious practitioners of the Hindu community. However, this outcome may not be as effective in the Protestant Church. This is mainly because the Protestant Church has great

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[7]Ibid

belief in the doctrine that a relationship with God should be a more personal one rather than communal. Therefore, while studies may reveal the importance of social support to religious practitioners contemplating suicidal ends, most of them are yet to clarify the specific aspects of social behavior that may act as a protective mechanism against stressors.

The Literature Review revealed differing views of religious doctrines regarding suicide of and afterlife. Following is a summary of the beliefs of the practitioners of Judaism, Catholicism, Protestantism, Buddhism and Hinduism.

Judaism

Judaism, as a religion, places great emphasis on life preservation. In its context, suicidal attempts are seen as a great violation of the sacredness of life. While this religion may have a keen interest in the overall goodness of mankind and its unwillingness to engage in traditional sins, it somehow endorses the idea that individuals are responsible for their own actions. Literature texts based on the religion of Judaism believe that since individuals are responsible for their good and bad behaviors, they are also capable of reforming. Historically, Judaism has always condemned suicidal behavior and attempts. Most believers considered it to be a great crime, and in some cases, even far greater than homicide. The reason is that the killers involved in homicides were believed to be incapable of repenting their sins.[9] Hence, according to Jewish traditional religious practices, individuals who commit suicide not only destroy their God-given souls, but also deserve eternal admonishment.[10]

Jewish people also believe that the eternal reproach given to suicidal victims should only be given based on the suicidal act itself and not to the individual that committed suicide. Moreover, research material on traditional Judaism beliefs reveal that only the Rabbi is

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[9] M, Leach, *Cultural diversity and suicide: Ethnic, religious, gender, and sexual orientation perspectives.* (New York: The Haworth Press, 2006), 245.

[10] Ibid.

allowed to rule a death as a suicide. Most of their rulings, therefore, usually based their arguments on the fact that individuals who suffer from either depression or social withdrawal are incapable of making successful suicidal attempts. While Rabbis are known for carefully examining the circumstances that may have led to suicidal deaths, most of them still rule out suicides as mere accidental deaths by the religious members of the community.[11] Ultimately, this perception is the main reason why the number of suicidal deaths among members of the clergy in Judaism remains negligible.[12]

Catholicism and Protestantism

Although Catholics and Protestants embrace teachings of the Old and New Testaments and represent a majority of the diverse array of religious traditions and practices worldwide, they have divergent beliefs when it comes to suicidal deaths. In the Catholic Church, for instance, the sanctity of life is considered to be the preeminent decision responsible for guiding the moral decisions made by members of the church. Furthermore, Catholics believe that the sixth commandment pertains not only to homicides, but to suicides as well. This is in line with their belief that those who commit suicide or show the slightest desire to take their own lives are liable for eternal punishment in hell. As a result, Catholics have imposed relatively more substantial sanctions against suicidal behavior in comparison to the Protestant Church.[13]

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[11] S. J. Kaplan, Defining *suicide: Importance and implications for Judaism,* Journal of Religion and Health 1988.

[12]Ibid

[13]M, Leach, *Cultural diversity and suicide: Ethnic, religious, gender, and sexual orientation perspectives.* (New York: The Haworth Press, 2006), 245.

Most Catholic religious practitioners, however, attest to the fact that the initial religious stance against suicide among the members of the clergy has softened. This stance was made public after the Pope declared that only God has the final ruling when it comes to matters concerning the eternal salvation of depressed pastors that have committed suicide.[14] Ultimately, the Catholic Church believes that despite the several reported incidents concerning suicidal attempts among the members of its clergy, only God can provide them with the opportunity for everlasting salutary repentance.

According to Shafranske, pastors who committed suicide in the Catholic and Protestant Church were denied honorable burials in church cemeteries for many years. This simply indicates that both the Catholic and Protestant Church show inconsistency when it comes to participating in some of the activities considered formal to the Church. Likewise, it shows that there is some level of disagreement between traditional and modern religious practices. For example, while both Churches embrace the idea that members of the Church can only grow closer to God as a means of their actions, they remain somewhat undecided as to whether suicidal actions defile the sacredness of life.[15]

Since sacramental life is considered to be the primary means through which members of the church can relate with God, there still exists an irreducible relationship between the church and its faithful members. Therefore, when examining the link between suicidal behavior and members of the clergy in the Catholic and Protestant Church, we can confidently assume that there are significant implications pertaining to such actions. However, the extent to which the clergy members are affiliated with the church may be

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[14]D. Lizardi, *Religion and suicide.* Journal of Religion and Health, 2009.

[5] E. P. Shafranske, Psychotherapy *with Roman Catholics.* (Washington, D.C: Handbook of Psychotherapy and Religions, 2000), 36.

directly related to how their religious beliefs influence their suicidal tendencies. Ultimately, one's personal relationship with God cannot be separated from their initial relationship to the church itself.

Some studies also reveal that both the Catholic and Protestant Church play a vital role in acting as a protective factor against suicidal attempts among members of the clergy. However, there is particularly minimal information based on the Protestant Church's point of view mainly because there are several denominations placed under the umbrella of the Protestant church. Despite the broadness of this category, sources reveal that there are foundation beliefs shared across all denominations in the Catholic and Protestant Church that reduce the occurrence of suicidal attempts among its members. For example, both Churches stress the need for accepting and turning to God for personal salvation. Both churches generally believe that by turning to God through accepting Jesus' sacrifice on the cross, the relationship between Man and God inevitably becomes a personal one.[16] This is the common religious doctrine in both churches that not only contrasts with the institutional practices of other churches, but also provides the foundation for condemning suicide.

In spite of the minimal coverage on the Protestant Church, religious practitioners agree that they also historically condemn suicide. The Protestant Church chiefly uses the Bible in its fight against suicidal behavior. For instance, one of their first saints, Thomas Aquinas, used biblical references based on Saul and Judas to build on writings that helped the church fight against suicide.[17] Likewise, the sixth commandment is also largely mentioned in anti-suicide campaigns because of their common belief that it is not only a sin against self and neighbor, but against God, as well.

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[16] M. E. Servis, *Handbook of Spirituality and Worldview in Clinical Practice.* Arlington, VA: American Psychiatric Publishing, 2004.

[17] D. Lizardi, Religion *and suicide.* Journal of Religion and Health, 2009.

Buddhism

Buddhism differs from other religions in that it finds its emphasis towards human suffering and general distress. Researchers believe that Buddhist beliefs may incline more towards lessening human suffering instead of satisfying human curiosity with regard to the origin and nature of some of their beliefs. Their religious texts have no mention of whether God's grace or divine intervention can provide solace for religious members suffering from religious internal conflicts. As a result, most Buddhists do not focus greatly on the idea of a divine presence. Surveys reveal that Buddhists center their beliefs on the four Noble Truths which provide guidance towards the Buddhist beliefs on suffering. The concepts behind the Four Truths explain forms of suffering relevant to human existence, the origin of suffering, the details of suffering, and the paths to alleviation of human distress. Contrary to other religious groups, Buddhists believe that human suffering results because of the human's desire for attachment to others. Therefore, their doctrine indicates that by eliminating certain levels of the desire to find human attachment, individuals may achieve relief.

Buddhists' attitudes towards suicide are considered as part of the fundamentals of human suffering. They interpret suicidal behavior as a craving for non-existence in the world of reality. However, Buddhists do not believe that suicide provides the end of suffering. Instead, they view it negatively as the killing of a sacred living being.[18] Buddhists believe that those who commit suicide will be reborn into even more woeful planes of human existence. Hence, their belief that suicide promotes, rather than shields human suffering, is the main cause for lower instances of suicide among its religious practitioners.

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[18]C. Disayavanish, & P. Disayavanish, "A Buddhist approach to suicide prevention," *Journal of Medical Associations of Thailand* 2007: 1684.

Hinduism

Hindus believe that every action in the current life has dangerous implications in the next life. This principle is referred to as Karma, according to Merriam-Webster Dictionary. The Hindus perceive that death by suicide could likely lead to further suffering, especially since they do not believe death to be the final stage of life. As a result, they have placed central concepts, such as Dharma,[19] within their religious doctrines that guide against suicidal behavior. Dharma simply entails the rules of required societal conduct. Selflessness and kindness constitute the core of the belief of Dharma, which places significant emphasis on the importance of human life.

Some of the Hindu Scriptures remain relatively neutral on the subject of suicide among its clergy members. While the belief that taking away one's life for the purpose of alleviating human distress is unacceptable, there may be uncertainties as to whether certain suicidal deaths may qualify as good deaths or bad deaths. Good deaths are those that follow long, fruitful lives. According to the Hindu doctrine, those who die good deaths are not only in good mental states, but can also say goodbye to their loved ones.[20] This concept, therefore, allows for uncertainties concerning circumstance under which a suicide may be ruled out as a good death.

Conclusion of Comparative Religious Beliefs

Examinations based on the traditional suicide beliefs of major religions ultimately prove that there are important common threads. If viewed from a broader perspective, each of the aforementioned religions shows a certain level of opposition to suicide among all the members of its church. All these churches place a fundamental importance on the sacredness

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[19] M, Leach, *Cultural diversity and suicide: Ethnic, religious, gender, and sexual orientation perspectives.* (New York: The Haworth Press, 2006), 248.

[20] Ibid.

of life; hence, they view suicide as a violation of their beliefs regarding suicide, regardless of the mental or emotional state of the victim in question. Moreover, the theoretical basis reveals that suicidal behavior should have serious implications, even if the final decision belongs to God in the afterlife. Therefore, this perception may generally affect whether an individual should spend eternity in hell for committing suicide or if it should affect the nature of other depressed pastors considering suicide as a form of escapism.

Since humans are created in the likeness and image of God, ultimately, there should be no reason to justify an attempt at taking one's own life. Human beings likeness to the Almighty Creator automatically places them in a position that can effectively eradicate the need for causing personal death. Research materials based on current religious beliefs indicate that traditional beliefs may have failed to lay a proper foundation for the fight against suicide among members of the clergy. A careful consideration establishes that suicidal attempts among depressed pastors not only send a negative message to other depressed members of the church, but may eventually force all religions into thinking that an attempt at one's own life may be indemnified by God during final judgment. While suicidal behavior is indeed reflective of one's underlying state of mind, it is still clear that it has a huge impact on the afterlife.

The research revealed that there is great diversity in both belief and practice within all religious traditions. Most religious groups have embraced conservatism as a weapon against suicidal behavior against members of the church. This eventually had negative implications on depressed pastors since it gave them no real outlet should they have desired to share their feelings concerning whatever had deterred their faith. Conservative religious practices may have expressed their negative attitude towards suicidal behavior, but it also blocked the avenue with which depressed members of the clergy could have acquired any kind of assistance. Similarly, there were other common variations of church attendance, core beliefs, adherence to biblical doctrines, and the frequency of prayer. These variations also tend to

have direct implications on an individual's ability to engage in suicidal behavior since it may eventually eliminate certain aspects regarding the adherence to practices forbidding suicide.

Understanding the relationship between religious practices and suicidal behavior among depressed pastors and members of the church could form the basis for prevention and treatment. Suicide in the church cannot be fought only by providing protective factors through religious and social groups, but also by increasing the knowledge of factors that may lead to the development of suicidal behavior. The specific mechanisms involved in suicidal behavior caused by religious beliefs may also be applied in treatments regarding agnosticism and atheistic tendencies. Research based on eradicating suicide among depressed pastors should therefore dwell on clarifying the needed social support in religious communities and integrating other potential mechanisms for the purpose of ensuring proper stress regulation.

Research regarding the relationship between different religions and suicide is scarce. There is minimal mention as to how different religions may eventually affect each other as a result of beliefs detailing the implications of suicidal attempts. Similarly, there is limited information specifying the ideations and attempts of religious practitioners in Hinduism and Buddhism.[22] Such information may be useful in understanding the frame of mind of practitioners that have contemplated the idea of suicide, and may also shed light on the effects that religious integration and acceptability of suicide attempts could have on committed followers of certain religious groups.

Future work may also be needed to reveal the circumstances under which religious based support may prove most effective. These may find the moral objections towards suicide attempts among religious practitioners in various religious groups. While it may be that a difference in attitude still fuels the high rates of suicide in the Catholic and Protestant Church, further research may help uncover some of the salient factors in suicidal behaviors in the church.

Statement of Methodology

To conduct this study, a thorough review of the literature relating to the causes and impact of depression on ministers will set the basis for this project. The project design will employ multiple approaches utilizing qualitative, quantitative, and case study methods. The qualitative method will consist of interview conducted with participants to ascertain information about the pastors' lived experiences, views, and feelings about depression. The content analysis of the data will be structured and coded into groups, hypotheses, and themes. The quantitative method will use a survey questionnaire. The purpose of the questionnaire is to gain an understanding of the experiences, beliefs, perceptions and feelings of the pastors.

With both the qualitative and quantitative methods the data will be collected and presented in a tabular form and analyzed through the frequency and percentage of respondents. A Likert scale will be applied to seek responses to closed-end questions. The case study method will be utilized to add strength to what we know about the causes and impact of depression.

The following section will show how the contents of each chapter in the thesis will be developed to respond to the research questions. Chapter 1 will introduce the project by outlining the purpose of the study, offering some general information and detailing what the study will and will not accomplish. It will also demonstrate the relationship between the topic and current practices in the ministry field and how the biblical theological data corresponds to it. The chapter will conclude with a summary of current literature such as books, academic theses, and scholarly journal articles. Chapter 2 will outline the research design for conducting the study on the causes and impacts of depression in pastors. The steps are the research methodology, data collection method, data sample background, research questions and hypotheses, ethical considerations, summary of methodology, instrumentation and assumptions and limitations. Chapter 3 will report the results of the applied research citing current experts in the field of ministry. The writer will supply an overview of the findings.

Finally, Chapter 4 will summarize the major points made throughout the project, interpret the findings, and examine implications for future research and consideration, especially among pastors.

Review of the Literature

The writer thoroughly reviewed a number of sources with a focus on the topics of suicide and depression, primarily in relation to pastors, in completing this thesis project. Related literature from the Bible, published books, scholarly journal articles, theses, and internet sites were utilized to support the research project.

Books

Benner, David. *Strategic Pastoral Counseling: A Short-Term Structured Model*. Grand Rapids, MI, Baker, 2003.

> Benner's study offers perspective on how pastoral counseling is carried out. It gives the study a religious perspective of counseling and how conventional methods need to be sensitive to the religious beliefs of pastors undergoing counseling or suffering from suicidal depression. The book is a guideline on how to counsel pastors and members of the clergy. Although it gives precedence to the religious and moral condition, Benner's study does not sacrifice on scientific knowledge and understanding of mental health issues.

Creswell, John. *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*, 2nd ed. Thousand Oaks, CA: Sage. 2003.

> Creswell's monumental work on data analysis and research approaches is a cornerstone to the methodology section of the paper. It highlights the benefits and limitations of various qualitative, quantitative and mixed methods approaches of data collection and determines how to make the most of information collected during the

research process. Creswell's work will be essential for the researcher to incorporate in the study.

Data Protection Act. The Stationery Office, London, 1998.

The Data Protection Act of 1998 has been monumental in demonstrating to researchers how data should be utilized, the importance of privacy and confidentiality when using the data and the importance of protecting information collected from individuals. Because the topic being researched is sensitive for both the participants and the investigator, the document will guide the researcher on best practices when handling sensitive data and how to utilize information collected from the study.

David, Robertson. *My Journey through Depression: A Pastor's Story*, (Strategic Book Publishing, 2011), 18.

David's book is a personal account of his journey through suicidal depression. It offers first-hand information from a member of the clergy, which is essential for a subjective approach of the topic. When using information from this source, the researcher is careful to note that given its subjectivity, some of the material may not be accurate. However, it adds to information from other pastors who are coming forward and talking openly about depression.

Finn, M. & Rubin, J. B, "Psychotherapy with Buddhists," *Handbook of Psychotherapy and Religious Diversity* 2000: 317-340.

Finn and Rubin's book is a holistic examination of how psychotherapy is approached across different religions. The particular section on psychotherapy is pertinent for the theoretical basis as it adds to the comparative methods different religions, in this case Buddhism, view mental health issues in their religious beliefs.

Greening. L, Stoppelbein. L. *Religiosity, attributional style, and social support as the psychological buffers for African American and white adolescents' perceived risk for suicide,* Suicide and Life Threatening Behavior, 2002.

Although Greening and Stoppelbein examine adolescents, their study is a comparative approach to suicidal depression in African American and Caucasian communities. The research offers insight on the prevailing attitudes towards mental health illness among members of the clergy of different racial inclinations. It offers answers to the question, "How does race affect a pastor's willingness to seek treatment for suicidal depression"?

Larson, McCullough. *Psychotherapy with Mainline Protestants: Lutheran, Presbyterian, Episcopal/Anglican and Methodist*, Handbook of Psychotherapy and Religious Diversity, 2015.

Larson's handbook is a holistic guideline on how different religious groups understand psychotherapy. The author reflects on how mainstream churches perceive mental health issues and their willingness to accept psychotherapy measures as a means of intervening when pastors and other religious leaders suffer from suicidal depression.

Lawson R, Wulsin M, Vaillant G, Wells V., *A systematic review of the mortality of depression. Psychosomatic Medicine*, 1999.

Lawson et. al. add a scientific and systematic analysis of suicidal depression as understood in conventional culture. Many of the clinical terms will be drawn from their review, including information on symptoms and causes as understood in the scientific spheres.

Leach, M. *Cultural diversity and suicide: Ethnic, religious, gender, and sexual orientation perspectives*. (New York: The Haworth Press, 2006), 241-51.

Together with the book by Greening and Stoppelbein, Leach's study encompasses the cultural and religious perspectives of mental health issues and suicide. The author isolates the variables that contribute to depression based on background and case

studies, then examines how these variable also work together to contribute to life threatening behavior among people from different cultural and religious backgrounds.

Nelson, Juthani, "Understanding and treating Hindu patients. In H. Koenig (Ed.)." *Handbook of Religion and Mental Health* 1998: 271-278.

Nelsons handbook is a holistic approach to the fields of religious studies and mental health. The section of specific interest is how patients of the Hindu faith seek treatment for mental health issues such as suicidal depression. The section is specifically relevant for inclusion in the theoretical basis of the study, as well as offering a comparative approach to how people from different religions deal with suicidal depression.

Servis, M. E., *Handbook of Spirituality and Worldview in Clinical Practice*. Arlington, VA: American Psychiatric Publishing, 2004.

Servis' handbook attempts to come to a theoretical and practical conclusion of a more culturally sound approach to counseling. It is ambitious in its attempt to encompass a "worldview" of clinical practices; however, this quality makes it a relevant reference point for contemporary clinical practices when dealing with mental health issues.

Shafranske, E. P. *Psychotherapy with Roman Catholics*. (Washington, D.C: Handbook of Psychotherapy and Religions, 2000).

Shafranske's study is relevant to the theoretical basis of this paper. It focuses on the Roman Catholic faith, which enables it to provide essential background and contemporary information on the perception and practice of psychotherapy among Roman Catholic adherents.

Journal Articles

Archibald, Hart, "Depressed, Stressed, and Burned Out**:** What's going on in My Life?" *Enrichment Journal* 23 (2015): 10.

Archibald's article adds to firsthand accounts by pastors who have or are suffering from depression. It provides information on the direct relationship between ministerial work and the likelihood of depression, stress, and burnout. Most importantly, it is a recent article, which gives immediacy to the information through a contemporary perspective.

Bonelli, Raphael, Dew, Rachel E., Koeing, Harold G., Rosmarin, David H., and Vasegh, Susan. "Religious and Spiritual Factors in Depression: Review and Integration of Research," *Depression and Research Treatment* 2012: 1-2.

Bonelli et. al. are instrumental in converging religious and spiritual factors in depression and how individuals can use religion and/or spirituality as a means of countering mental health issues. The paper accomplishes this through vignettes and case studies of individuals suffering from depression and using their religious backgrounds as a support measure. It also examines how religion and spirituality can be a cause of depression. While focusing on the spiritual, the paper also highlights scientific information relevant to the study.

Bryant, Keneshia, Greer-Williams, Nancy, Willis, Nathaniel and Hartwig, Mary. "Barriers to the Recognition and Treatment of Depression: Voices from the Rural African-American Faith Community," *Journal of National Black Nurses Association 24*, 1: (2013) 31-38.

Bryant et. al. recognize that religious inclinations especially among African Americans can significantly contribute to their willingness to admit to suicidal depression and their tendency to seek treatment. The scholars examine the role religion plays relative to treatment, symptoms and causes of depression. Much of the paper highlights the stigma surrounding depression and the inability to openly discuss it, which mars any intervention methods, clinical or otherwise.

Disayavanish, C. & Disayavanish, P, "A Buddhist approach to suicide prevention," *Journal of Medical Associations of Thailand* 2007: 1680-1688.

While many articles focus on clinical methods of dealing with depression and preventing suicide, Disayavanish and Disayavanish examine how the Buddhist faith can also be used as a means of seeking treatment and healing. The information from this article is encompassed in the theoretical basis for the project and incorporated in treatment assessments.

Duke University, "Clergy More Likely to Suffer from Depression, Anxiety," *Duke Divinity School*.

Duke University's School of Divinity has led in a substantial amount of research on prevailing issues affecting religion today. In this article, they examine why members of the clergy are more susceptible to depression. It offers empirical evidence of depression across religious groups, causes and manifestations of the same, while also examining the perception of mental health issues in the pastoral community.

Ellison, C. G. & Levin, J. S, "The religion health connection: Evidence, theory and future directions," *Health Education and Behavior* (1998): 700.

Ellison and Levin write about how spiritual health is deeply connected to mental and physical health. They present empirical evidence in the form of case studies and vignettes, and construct theories based on their analysis of evidence, positing these theories as a means of examining "religious health."

Fiala, W., Bjorck, J. P., and Gorsuch, R, "The religious support scale: Construction, validation, and cross-validation," *American Journal of Community Psychology* (2002): 761.

Fiala, Bjork and Gorsuch's religious support scale is instrumental in offering validation for its effectiveness in treating clinical depression and other mental health conditions without considering clinical intervention measures. The article is especially helpful with its empirical investigation on the subject.

Givens, Kelly, "Why are so many pastors committing suicide?" Crosswalk, 2013.

Givens' article attempts to answer the question it poses by offering situations and contexts for why different pastors in recent years have committed suicide. She links the prevalence of pastors committing suicide to family issues, relationships and ministerial work. Although her work is not scholarly, the information correlates greatly with peer-reviewed articles and papers and offers a substantial amount of empirical evidence. Her article is particularly useful in highlighting the correlation between the lifestyle of pastors and the likelihood of depression based on statistics from the Shaffer Institute.

Goodall, Wayde. I., & Wagner, Glenn. "Coming out of the Dark: Two Pastors' Journey out of Depression" *The Enrichment Journal,* 2015.

Goodall and Wagner offer information on how Christian counselors have been instrumental to their healing process. They also discuss medication that is acceptable in the pastoral community and morally appropriate channels through which pastors can seek both clinical and ministerial support for dealing with depression.

Graham, Andrew James. 2013. Conservative Holiness Pastors' ability to assess depression and their willingness to refer to mental health professionals. *Thesis Dissertation Liberty University*, 2013.

Graham's thesis focuses on depression in Conservative Holiness Pastors and is a strong case study on how mental health issues affect members of the Conservative Holiness Church and how they choose to assess the matter and seek treatment. His survey instrument is especially helpful for the investigation of this paper as it condenses necessary information.

Greg, Warner, "When depression leads pastors to suicide," *The Christian Century* 24 (2009): 14.

Greg's paper offers the direct link between suicide and depression in the pastoral community, while also paying attention to scientific information on the causes, symptoms and manifestations of depression. Greg spends an extensive amount of time discussing suicide as the height of depressive behavior and the need to look out for early warning signs to prevent such an occurrence.

Hallowell, Billy, 'The Darkest Time of my Entire Life': Preacher Reveals the Struggle that nearly led to his Death" *The Blaze*, 2014.

Hallowell, like other pastors in the Literature Review, offers his personal account of depression. His article personalizes perspectives and adds to the intertextuality of the paper and of religious scholars in light of suicidal depression.

Kaplan, S. J. Defining suicide: Importance and implications for Judaism, *Journal of Religion and Health,* 1988.

Kaplan's paper analyzes suicide entirely from the perspective of Judaism. Through references to the Bible, the paper defines suicide, looks at conditions where characters in the Bible committed suicide and how that relates to contemporary perspectives in Judaism.

Knott, Andrew, “Top Ten Causes of Depression in Pastors,” 2014.

Knott provides a definitive list of the leading factors that result in depression in pastors. Much of the information is condensed, which may not be beneficial for scholarly purposes; however, it is a glimpse into the causes of depression that can be compared against scientific and scholarly information. Knots “Top Ten Causes of Depression in Pastors” is also easily accessible for non-scholarly audiences who wish to understand the topic.

Lizardi, D. Religion and suicide. *Journal of Religion and Health*, 2009.

Lizardi writes logically and incisively on the direct link between religion and suicidal tendencies. It includes information on how religion can contribute to one’s susceptibility to suicide and how religion can also discourage suicide because of the stigma and negativity towards destructive behavior and psychological conditions.

Mariottini, Claude, “When Pastors Kill Themselves” Claude Mariottini, 2014.

Mariottini’s article is a haunting account of recent suicides that have taken place in a number of pastoral communities in the United States. It contextualizes each situation and urges for intervention measures to be put in place within the clergy to prevent such occurrences. One of the issues the article highlights is that despite current knowledge and understanding of suicidal depression, it is still a prevalent issue affecting religious communities.

Merritt, Jonathan. “Megachurch Pastor Perry Noble Admits to Depression, Suicidal Thoughts” *Religion News Service*, 2014.

Merritt’s interview with Pastor Perry Noble of the Megachurch is essential for addition in first-hand accounts of suicidal depression in pastors. The admission is a powerful inclusion in the literature review, as well as in the discussion on the topic, as it reduces stigma surrounding the subject and gives much-needed contemporary background to the study.

Payne, Jennifer Shepard. “Variations in Pastor’s Perceptions of the Etiology of Depression by Race and Religious Affiliation,” *Community Mental Health Journal* 45 (2009): 355-365.

Payne’s article is insightful in offering definitions for terms related to depression as understood by individual pastors, as well as across religious spectra. Her work is important in coming up with definitions for the paper and providing background on how religious affiliation affects pastors’ perception of depression and treatment.

Simons, Robin, W. Revisiting relationships among gender, marital status and mental health, *American Journal of Sociology*, 107 (2003): 4.

Simon’s paper is a sociological approach to mental health and how it affects relationships between individuals. It critically examines the care systems and how one’s environment contributes to the success of treatment when suffering from mental health conditions.

Timothy, Morgan. 2013, “Rick Warren's Son Dies from Suicide,” *Christian Today*, 2015.

The article by Timothy highlights the plight of a well-known spiritual leader as a means of humanizing suicidal depression. From such articles, the paper gains from the personal experience of pastors and the ways in which the clergy is opening up on mental health issues and suicidal depression.

Tripp, Paul. 2013, “The depressed pastor: the setup” Christianity, 2015.

Tripp’s blog discusses various issues in the pastoral community. In this article, Tripp gives hypothetical as well as realistic situations in which pastors are likely to exhibit symptoms of depression. He examines these from personal relationships to pastoral demands and empathizes with each of the situations. Though not scholarly, the blog’s tone enables easy access to information and understanding outside scholarly circles.

Trivedi, Madhukar, H., “The Link between Depression and Physical Symptoms,” *Primary Care Companion Journal of Clinical Psychiatry* 6 (2006): 12-16.

Trivedi’s article is instrumental in identifying the physical symptoms of

depression. Depression is often understood as an abstract, emotional condition; however, it also affects one's physical condition and such manifestations can help make the status of an individual more accessible for clinical intervention. Although it is a peer-reviewed scientific article, its credibility makes it a useful source of information even for lay members of the pastoral community and enhances their understanding of the manifestations of depression.

Wasserman, Stack. The effect of religion on suicide ideology: An analysis of the networks perspective. *Journal of the Scientific Study of Religion*, 1992.

Wasserman's paper is not just a scientific investigation of suicide; it provides theory on the subject. The paper uses Scripture as a means of interrogating suicidal behavior and justifying its prevalence in contemporary religious culture.

Willoughby, M. T, "An evaluation of the psychometric properties and criterion validity of the religious social support scale," *Journal for the Scientific Study of Religion* (2008): 149.

Willoughby's paper highlights the psychology of religion and how religious psychology can be used as a means of treating mental health illnesses. While religion and religious texts have minimal scientific basis, Willoughby urges scholars not to undermine their potential as tools of psychotherapy. He outlines the properties of this tool and justifies its benefits as well as its limitations.

In conclusion, Chapter 1 outlined the components of the foundation of the study. The components introducing the study are the background and statement of the problem, purpose of the study, its significance, limitations, theoretical basis, methodology and review of the literature.

Now that the foundation has been established, Chapter 2 will describe the steps to be taken to study the problem. The research methodology, data collection method, data sample background, research questions and hypotheses, ethical considerations, summary of methodology, instrumentation, and assumptions and limitations will all be delineated in the next chapter.

CHAPTER 2

RESEARCH DEVELOPMENT

The critique of literature plays a significant role in examining existing information. The process helps to clarify the researcher's thoughts about the study and establishes a framework for presenting and analyzing the findings. It supports the relevancy of the study and why it is worth researching. The mental health issue to be studied in this dissertation is not an exception.

The writing of a dissertation requires strategic planning in conducting the research project. The planning entails choosing a topic, developing research questions or problems, establishing a map to outline the steps to follow in conducting the research, organizing the research and reporting it. These are the steps that this researcher will implement in conducting this study on the causes and impact of depression on pastors.

The purpose of this study is to understand the issues that would cause a pastor to become depressed and to devise a plan of action that will provide alternatives to dealing with depression in a positive and healthy manner. This chapter will describe the research methodology of the study, justify the sample selection and how responses varied based on the respondents in the sample group, describe the procedure used in designing data collection instruments and describe how they have been used to obtain information for the study. This chapter will also provide an explanation of the methods used to analyze data and gather statistical information, make connections between the data collected for the study and information gathered from the literature review, reiterate the research questions and correspond them with a null and alternate hypothesis.

Much of the literature discussing depression and suicidal tendencies in pastors uses qualitative research to draw conclusions on the behavior and how suicidal depression is linked to the church. The pattern noted is that theology-based articles are more qualitative, so they focus on the causes and symptoms of depression in pastors. On the other hand, psychological and sociological studies also incorporate quantitative figures, however, these

merely give information on the probability of pastors suffering from depression as well as figures highlighting the number of clergy who are diagnosed as depressed. Because most pastors are unlikely to admit that they are depressed due to the stigma both within the church and in society, this paper will argue that the quantitative data in most of the research may be on the lower side.

Research Methodology

The methodology to be used generates a broad physiological basis for supporting the chosen research model. A mixed-method is chosen because it combines qualitative and quantitative approaches to the research project. The method collects qualitative and quantitative data and interprets that data. The qualitative research explores depression as a mental health issue and identifies major themes. The quantitative research answers questions and null hypotheses and uses a descriptive research design. A disadvantage is that the method is different in each approach. An advantage is that the method garnishes more data. The above blueprint depicts how the researcher will conduct this study.

A descriptive research methodology was used for this study. A longitudinal study that followed participants over time would not fit this research as the population investigated was situated within a small area and were a small number.[21] Based on the theories formulated by John W. Creswell, a cross-sectional survey was chosen as this design has been shown to be an effective strategy when working with attitudes, values, and beliefs and can be conducted in a short period of time and with little cost.[22]

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[21] Robin W. Simons, Revisiting relationships among gender, marital status and mental health, *American Journal of Sociology*, 107 (2003): 4.

[22] John W. Creswell, *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*, 2nd ed. Thousand Oaks, CA: Sage. 2003.

The qualitative and quantitative results of this paper were drawn from a case study of pastors and clergy of the Grace City Church, a primarily African-American congregation, in an urban city in the South. Responses are gathered from a series of interviews conducted with members of the church and represented appropriately against themes relating to suicidal depression. As a case study, this paper enabled a focused approach in drawing data and provided a means for the researcher to incorporate quantitative analysis when examining suicidal depression as it relates to Grace City Baptist Church. The information was correlated with insight drawn from the literature review and used for qualitative analysis.

As mentioned earlier, the pattern used in theological papers is the application of qualitative methods, which offers insight on depressive habits in pastors without providing supporting data. Psychology and sociology papers offered quantitative data, however, this information is not rationalized with qualitative information. For this reason, this study employed a mixture of both qualitative and quantitative methods necessary for the information drawn through each method to support the other. For instance, while qualitative methods enable broad and nuanced interpretations, the information can only be made concrete through figures provided by quantitative approach.

Qualitative data was drawn through interviews with members of the Grace City Baptist Church. Questionnaires tend to be the more appropriate form of drawing both qualitative and quantitative data because they collect standardized information, however, they tend to be rigid and a lot of care needs to be taken in their design and delivery. Interviews, on the other hand, are more flexible and are a more comfortable option for such a sensitive topic as depression and suicide within the setting of the church. Interviews are more personal to the respondents and enable the researcher to establish a rapport and, more importantly, trust with his subjects. Given the sensitivity of the topic, the researcher theorized that interviews would enable respondents to participate in the study on an individual and private basis, which gives liberty to their responses and enhances the information collected.

Data Collection Method

The collection of data for this research project involves several variables taken under consideration. The researcher develops an idea thought to be relevant to pastors' mental health stability; after the idea is selected, a useful question is informed. The question should be answered from the research review. The question asked in this study is, "What are pastors do when struggling with personal issues?" The answer can be formulated from the collection of meaningful data.

In this case study, the research is grounded at the Grace City Baptist Church, affording the researcher the opportunity to interact with the pastors to be interviewed within their environment. A series of interviews is favored because an interview is a useful means of drawing qualitative information about an interviewee's experiences, perceptions and feelings. The researcher is able to prompt the subject for further clarification, which increases the information necessary for the study and gives room for a varying number of hypotheses as well as answers to the research questions. The sample selection for the interview narrows the focus to a few candidates, making information succinct and the quantitative information drawn more concentrated.

The researcher notes that while interviews offer a substantial amount of information that is useful to a holistic understanding of the topic, it is a time-consuming process. Furthermore, unlike a questionnaire that is more structured, interviews can lead to error in data collection because the responses are less controlled and follow-up questions rely heavily on previous responses. This can lead to a range of information that is too wide, necessitating a "narrowing down" of questions to themes and topics.

Data Sample Background

The Grace City Baptist Church was chosen to enable a focused case study of pastors from a single congregation. The church was founded in 1862 and has over seventeen hundred members. The current pastor, Martin E. Johnson, presides over a nine-person Board of Directors. The church is governed by its own by-laws that are drawn from the Board of Directors' recommendations and are used to provide guidelines on congregational votes. Small group ministries are emphasized and these more intimate settings are credited for the successful operational model. The small groups facilitate Bible study, parenting classes, as well as non-traditional church activities. An executive pastor oversees church business while the Board of Directors is responsible for dispute resolution and discipline.

Aside from its leadership and operational structure, Grace City Baptist Church and its members have experienced controversial occurrences during operations, and it is for this reason that the church holds interest to the researcher. In 2013, the pastor of Grace City Baptist Church was scheduled to preach the pastor's anniversary service for his father-in-law in another town. Instead of attending the service, he committed suicide in the drive way of his home as his family and congregation awaited his arrival at the church. This forty-two year old pastor came from a devout Christian family. Given such a background, the researcher believes that the Grace City Baptist Church is an appropriate setting to investigate suicidal depression and its manifestations.

Grace City Baptist Church has seventy-seven members of the clergy, all African-American; forty members agreed to participate in the study.

Respondents were given the choice of selecting from a variety of reasons for non-participation in the interviews. A small number of pastors cited their reason for declining to participate as "I'm too busy." Another reason for non-participation was, "I'm uncomfortable," which was cited by sixteen percent of respondents, "I do not understand,"

was selected by eight percent of respondents, and "It may conflict with personal feelings," was chosen by three percent.

Instrumentation

Reliability and accuracy are the most important aspects of research. To achieve both reliability and accuracy, the interview has to be designed to obtain applicable information from the respondents. The interview questions used for this study were designed to enable the researcher to obtain data for various purposes. To ensure these purposes were met, the researcher carefully followed the instructions set out by Creswell who provides useful guidelines for setting questions in questionnaire or interview formats when conducting research.

As noted earlier, one of the disadvantages of the interview format is that questions may not follow the same format as they depend on the responses received. However, to ensure high reliability of responses, the questions were themed around specific topics for a balanced response and a wider interpretation of qualitative data. Various scholars note that reliability can only be achieved if the researcher incorporates a number of precautionary steps. The table below lists four steps required to ensure reliability.

Table 2.1

Steps to Ensuring Reliability

1	Each question is clearly and easily understood.
2	Interviewees interpret each item in the manner it was intended.
3	The items have an intuitive relationship to the topic and goals
4	The intent behind each item is clear to colleagues knowledgeable about the subject.

The interview consists of twelve questions divided into two sets. Each interview set is designed for specific thematic issues to be addressed and raised. The first set, which contains eight questions, examines the structure of the Grace City Baptist Church in order to

establish the background of the study. These questions include an investigation into the core values of the church, its mission statement, the leadership structure, the church's strategic plan and its implementation and how the success of the strategic plan is determined. From this information, the researcher is able to determine the environment of the case study area and understand how the pastors work within the leadership and management structure.

The second set of four interview questions examines how depression is perceived by the pastors on a personal level. The perception relates to their views of the effects of the illness and coping strategies. The information ascertained enables the researcher to determine the pastors' current level of consideration of depression as a health issue.

The most important interview for the study, however, is the thesis interview which goes to the root of the issue, suicidal depression in pastors. The interview is designed to be conducted on a one-on-one basis, where the researcher interacts with the subject privately in order to obtain open responses. Given the sensitivity of the interview questions, consent was required from the participants as well as their full understanding of what the interview sessions entailed and how the information will be useful. Some of the questions were designed to understand the participants' pastoral role and how that affects their professional and personal lives. The interviewer sought to examine the participants' interaction with their environment and other members of the clergy in their congregation.

The twelve interview questions were structured around themes to enable easy tabulation of information. The themes were used to create a means of surveying the responses. A survey instrument taken from an earlier study on the topic was also used as a means of analyzing responses.[23] The five themes identified are shown in the following table.

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[23]Andrew James Graham, Conservative Holiness Pastors' ability to assess depression and their willingness to refer to mental health professionals. *Thesis Dissertation Liberty University*, 2013.

Table 2.2
Interview Questions Themes

Theme 1	Attitudes towards Mental Health
Theme 2	Causes of Depression
Theme 3	Perceived Competency
Theme 4	Recognition of Need for Help
Theme 5	Confidence in mental Health Professionals

Responses for the first three themes, "Attitudes toward Mental Health," "Cause of Depression" and "Perceived Competency," *w*ere identified on a 5-point Likert scale (strongly agree, partly agree, not sure, partly disagree, strongly disagree). Below is a listing of the statements in the survey to which study participants responded.

Attitudes toward Mental Health Scale:

1. When you get right down to it, depressed church members should not be a clergyman's responsibility. Therefore, they should be referred to mental health practitioners.
2. Mental health practitioners are too evasive when it comes to facing a problem.
3. I feel the work of a mental health practitioner conflicts with the work of a pastor.
4. I feel the majority of emotional disturbances should be handled by the clergyman.
5. On the whole, mental health practitioners are very competent.
6. Psychiatric treatment takes too much time and gets really poor results.
7. The mental health practitioner's attitude toward the patients and their problems is, for the most part, a positive one.
8. In my opinion there are more "odd-balls" in psychiatry than any other profession.
9. I feel that mental health practitioners overemphasize the sexual aspects of life as a cause of mental disorders.
10. I have been greatly impressed by the results of psychiatric treatment.

Causes of Depression Scale:

1. Loneliness is a cause of depression.
2. Trouble getting along with one's wife or husband is a cause of depression.
3. Demonic influence is a cause of depression.
4. Drinking too much is a cause of depression.
5. Lack of religious belief is a cause of depression.
6. Not enough will power, lack of self-control, is a cause of depression.
7. Trouble adjusting on the job is a cause of depression.
8. Stress is a cause of depression.
9. Excessive drug use causes depression.
10. Self-pleasure is a cause of depression.
11. Depression is learned.
12. Depression is inherited.
13. A run-down physical condition is a cause of depression.
14. Sex habits are a cause of depression.

Perceived Competency Scale

1. In general, I feel quite comfortable in caring for depressed congregations.
2. I feel pretty competent and comfortable in talking with congregations about their personal problems.
3. My training and experience are such that I feel competent to take on most cases of depression among my congregations.
4. I do not know what to do for many of my depressed congregations.
5. I do not have the background to help depressed congregations.
6. My training and experience in handling depressed congregations are adequate.
7. My background severely limits my having much success with depressed congregations.

8. I have a good understanding of how to help depressed congregations.
9. Most depressed congregations need more help than I can give.

Responses for the last two themes, "Recognition of the Need for Help" and "Confidence in Mental Health Professionals" were identified on a 4-point Likert scale (agree, partly agrees, partly disagree).

Recognition of the Need for Help:

1. There is something admirable in the attitude of a person who is willing to cope with depression without resorting to professional help.
2. I would want to get professional help if I were depressed for a long period of time.
3. I might want to have professional counseling in the future.
4. Considering the time and expense involved in professional help, it would have doubtful value for a person like me.
5. A person should work out his or her own problems; getting professional help would be a last resort.
6. Personal and emotional trouble, like many things, tends to work out by themselves.

Confidence in Mental Health Professionals:

1. If I believed I was depressed, my first inclination would be to get professional attention.
2. The idea of treatment by a mental health professional strikes me as a poor way to get rid of emotional conflicts.
3. If I were experiencing serious depression at this point in my life, I would be confident that I could find relief in professional help.
4. A person with depression is not likely to get better alone; he or she is likely to get better with professional help.

Method of Anaysis

The data analysis consists of surveying responses to interview questions for consistency, coherence and clarity. Responses will be arranged based on the different themes to determine the frequency of each theme in responses and how the theme relates to the research questions and study. Frequency tables and descriptive statistics will be constructed to display results. The responses from the forty study participants were used for data analysis.

Assumptions and Limitations

This investigation involves the use of a case study based on one church, Grace City Baptist Church. While it may act as a representative sample of a pastoral community, depression is too complex to properly encapsulate in the case study of a single church. Furthermore, such a setting assumes that most pastoral communities operate on a similar level. However, as seen in the theoretical basis, different religions have different ways of dealing with matters related to suicidal depression. The responses drawn from the pastors in this study can only be used on a general basis or hypothetically.

The interview and survey employed in this investigation are dependent on the personal responses of the pastors themselves. The investigator took steps to assure that the survey instrument was clear and that the study participants understood that their survey and interview responses would remain confidential and anonymous. The investigator assumed that pastors would be honest in their responses if they felt their personal responses would not be identifiable, thus limiting the risk of dishonest responses. Yet, the desire to demonstrate competency could be a reason that pastors' might not be totally truthful in their responses.

The instrument condensed the elements from several disciplines, including that of psychologists, psychiatrists, clinical social workers, psychiatric nurses, marriage and family therapists, and licensed professional counselors, into one category: mental health professional. However, pastoral counselor was presented individually. While pastoral counselors do have differing theoretical and practical strategies, the extent to which participants understand these nuances is unknown.[24]

While surveys were administered at Grace City Baptist Church, it is possible that the participants were not representative of all the ministries at the church, since thirty-seven of the seventy-seven pastors did not participate in the interviews and corresponding survey. Furthermore, the investigator is not a pastor or a member of the selected church, yet he does identify with the Christian faith and is currently a student of a theological college.

In addition to the utilization of the survey and questionnaire instruments to compile data on the pastors' opinions, beliefs, and attitudes towards depression, another area of concern should be considered. The area of concern is the application of specific models as implementation methods for prevention and intervention for those preparing to enter the field of ministry and for those currently serving as pastors. Research in this domain is not abundant, but it is the opinion of the researcher, that it will be expanding. Two such models that currently exist are C.A.R.E. and Seminary.

As an assumption, the researcher believes that the pastors' theological and secular educational experiences will largely influence their decisions to intervene in cases of depression.[25] According to the literature review, pastors in general do not believe in seeking solutions to depression within the church or from their families, but are more likely to try to

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[24] David Benner, *Strategic Pastoral Counselling: a Short-term Structured Moral*. Grand Rapids, MI, Baker, 2003.

[25] Jennifer Payne, "The Influence of Secular and Theological Education on Pastors' Depression Intervention Decisions," 1412.

deal with their issues internally. The models will give alternatives to churches and religious institutions which will help them assist pastors suffering from depression. The models are not limited to mitigating depression, but also to prevent onset of the mental illness.

In a study carried out on shepherding flocks, doctoral student Ronald Edwin Hughes suggests two models of pastoral care: the church model named C.A.R.E, and the seminary model.[26] These models have been selected because of their suitability to pastors dealing with depression who would not use conventional models of treatment and management such as medication and therapy.

As a result of the survey to be administered, the researcher believes that a number of respondents will disclose that they have taken at least two courses in counseling while undergoing pastoral training. As a matter of opinion, this study will note that seminaries are instrumental environments that can equip soon-to-be pastors with the skills needed to cope with depression. This paper will come up with a suitable seminary model for the intents of the study. A need exists for the development of a suitable seminary model for evaluating its effectiveness as a preventative method.

Scholar Wayne E. Oates defines care in pastoral work as "combined fortification and confrontation of persons at times of both emergency crisis and developmental crisis."[27] A variety of examples given by Oates on what constitutes comfort and confrontation in pastoral care include birth, marriage, baptism, significance milestones, death and retirement. Although pastoral care is needed most when pastors are going through trying times, Oates believes in a more holistic approach to comfort, which balances moments of distress and those of

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[26]Ronald Edwin Hughes, "Shepherding the Flock – C.A.R.E: a model for Pastoral Ministry," *Thesis Liberty University*, 2015.

[27]Wayne E. Oates, New Dimensions in Pastoral Care (Philadelphia: Fortress Press, 1970).

celebration. As useful as Oates' perception of pastor care is for the everyday stream of life activities, it is also applicable when emergency issues arise.

In the church model, pastors dealing with depression would be cared for through the C.A.R.E. Model, which incorporates the principles in Oates' definition of pastoral care. According to Hughes, who developed the model, the acronym C.A.R.E. stands for Counsel, Affirm, Resource and Equip.[28] Hughes argues that the C.A.R.E. model is flexible to add and take away elements as per the sentiments of the church and the leadership structure of the church. Nevertheless, he warns that there should be a functional leadership structure in order for the model to perform effectively.[29]

Overall, the C.A.R.E. model enables pastors to become dependent on faith in a healthy way. The model provides both breadth and depth of care, especially for pastors dealing with depression or related traits. Although the role of the pastor is to ensure a healthy organization, they can only do so when their own faith and mental health are optimum and when they have a support system that enables them to deal with day-to-day stream of life crises and issues.

The second model is called Seminary. The need for a Seminary model is justified by the fact that in many instances, courses on counseling and depression are electives. As a result, pastors undergoing seminary training have the choice of enrolling in these courses and this choice means that they have little impact on their overall training and qualification as pastors. Consequently, pastors may not fully understand the subject of depression when it pertains to themselves or fellow members of the church. The Seminary model ensures that

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[28]Hughes, "Shepherding the Flock," 51.

[29]Ibid.

pastors have practical knowledge and application of counseling of depression, one that is beneficial for themselves and others.[30]

Hughes argues that, undoubtedly, pastors and ministers need "knowledge of resources, strategies and programs" that enables them to deal with pastoral care for depression as soon as a pastor begins offering services at their local church.[31] This obvious need justifies the consideration being given to require pastors in the ministry to take courses giving the skills, knowledge and understanding, in the form of intensive and perhaps compulsory sessions, during seminary or the semester. In addition to seminary courses, pastors can take workshops that place emphasis on collaborative learning experiences that enable students to become effective clergy members.[32]

Hughes' study points out that pastors face adverse personal and intimate issues that lead to depression or at least cause symptoms of depression. Accordingly, pastors should be adequately prepared to prevent a severity of depression cases and to make them effective members of the church community. Most importantly, Hughes argues that ministers seeking ways of ensuring pastoral care, in this case against depression, should honor the Lord and guide pastors towards a richer relationship with Christ and the church.

With this seminary model, Hughes posits that there should be five course objectives.[33] The first course objective is for students to identify a variety of caring ministries that their church can engage in so that the congregation is reached out to effectively and inclusively. The second course objective is for students to evaluate models of caregiving and select the

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[30]Ibid.

[31]Ibid.

[32]Ibid.

33Ibid.

most practical approach addressing the depression issue. The third objective is to train students, based on the selected model, to facilitate caregiving and to use caregiving models for themselves and for members of the congregation. The fourth objective is to introduce seminary students to procedures that enhance caregiving for pastors with depression, and the fifth and final objective is for student to develop a pastoral care plan.[34]

In addition to the course objectives, the Seminary plan includes eight major topics, still, the list is not exhaustive. Depending on the needs of a pastor or student, other topics can be added. For this particular study, the eight topics include benevolence, church discipline, counseling and counseling referrals, bereavement, spiritual crisis, crisis resolution, physical needs such as illnesses, hospitalization or disease and finally, training in lay counseling and pastoral care. The topics are taught holistically, offering historical background, in-class practice and field practicum on the application of a variety of methodologies.[35]

Finally, the Seminary and C.A.R.E. models are mechanisms that can be used for further study in finding ways to address mental help issues, especially depression. A balance of both the C.A.R.E. and Seminary models would be a good way to deal with the issue of depression in pastors. The C.A.R.E. model ensures that the principles, philosophies and theological teachings of the church are reinforced and are a conscious element of management, care and treatment. The Seminary model provides a good educational foundation that makes pastors aware of issues surrounding depression and how to offer

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[34]Ibid.

[35]Ibid.

pastoral care within both conventional and church models to people suffering from depression. It is also very practical and places pastors in a decision-making position, which is important when they have to determine which course of management or treatment is suitable for their condition. The instrumentation process will identify the tools necessary to collect data to answer the research questions and test the hypotheses.

Research Questions and Hypotheses

To conduct the study on depression and suicide in pastors, it was important to develop research questions that would elicit responses that would address the thoughts, ideas, and feeling about depression that could possibly lead to suicide. The researcher developed four questions that he believed would be appropriate for the study.

Table 2.3 Thesis Research Questions

Research Question 1	Do pastors have an understanding of the cause of depression and how do they vary for pastors?
Research Question 2	How do the lifestyles of pastors and their work make them susceptible to depression?
Research Question 3	Are pastors willing to admit to the fact that they are depressed?
Research Question 4	Are pastors willing to seek professional assistance when dealing with depression?

For each research question, a null and alternate hypotheses, and in one case, a secondary null and alternate hypotheses are presented below.

Research Question 1. Do pastors have an understanding of the causes of depression and how do they vary for pastors?

Null hypothesis: Because they have spiritual backing, the causes of depression in pastors are different from conventional causes of depression. Pastors are unlikely to feel like other people because of their elevated position in the societies they serve.

Alternate hypothesis: The causes of depression in pastors are similar to those in other people. As seen in much of the literature in Chapter 2, similarities occur not only in causes; they can also be seen in physical, psychological and mental symptoms.

Research Question 2. How do the lifestyles of pastors and their work make them susceptible to depression?

Hypothesis: The lifestyles of pastors make them susceptible to depression because of the high expectations placed on them during service as well as within the community. The literature review section offers extensive evidence demonstrating a correlation between suicidal depression in pastors and their lifestyles as well as work.

Research Question 3. Are pastors willing to admit to the fact that they are depressed?

Null hypothesis: Pastors are not willing to admit that they are depressed because they fear stigma and retribution from clergy members as well as the public. In addition to this, pastors are not willing to admit that they are depressed because of their inability to assess whether they or other members of the clergy suffer from depression.

Alternate hypothesis: Pastors are willing and able to admit to depression because they have developed a better understanding of its causes. Furthermore, they are able to receive more support from the clergy and pastoral community once they come forward with their admission. They also encourage other members of the pastoral community to openly discuss depression and find means of managing the problem.

Research Question 4. Are pastors willing to seek professional assistance when dealing with depression?

Null hypothesis: Education, training, years of pastoral ministry and the size of the clergy has little influence over the choice of pastors to choose professional assistance to deal with depression. In fact, their spirituality keeps them from seeking professional assistance as they believe it goes against Biblical teachings and the principles of the pastoral community.

Alternative hypothesis: Education, training and years of pastoral ministry have a positive influence on the choice to seek professional assistance for suicidal depression. It increases exposure to mental health issues, giving pastors a greater understanding of the need to seek assistance from people capable of assisting them deal with depression appropriately.

Secondary null hypothesis: Attitudes towards mental health issues coupled with the perception of professional guidance counselors have an impact on the pastoral community's use of professional assistance. Because of their non-affiliation to the church, pastors are unlikely to seek for help from medical professionals.

Secondary alternative hypothesis: There is increasing evidence of pastors seeking assistance from professional guidance counselors who are affiliated to their beliefs. It reduces conflict that pastors may feel relating to the principles of the pastoral community and increases their confidence on the ability of professional assistance to address their issues appropriately.

Ethical Considerations

The investigator was careful to protect the rights of each participant. Prior to the interview sessions, each interviewee was afforded the opportunity to peruse the informed consent documents. In addition, the informed consent papers were brought to the interview venues so that the participants' would be able to review the purpose of the study and their roles in the study. Participants were given appropriate information on how their contributions will be used. The researcher will ensure that participants understand applicable risks as well as potential benefits of participating. The responses will be kept anonymous so as not to jeopardize confidentiality.

Deliberate attention has been given to aligning consent with the Data Protection Act of 1998, which stipulates that "data will be used exclusively for research purposes.[36] The document ensures that information "will not be used to support measures or decisions relating to *any* identifiable being" or "in a way that can cause or is likely to cause damage to the data subject." Confidentiality will be protected by the safe storage of data in a password protected device or securely locked as deemed appropriate by the researcher as outlined in the Data Protection Act.

Summary of Methodology

The purpose of the methodology section was to outline the research methods used for the paper, explain the sample selection, delve into the research rationale and describe the procedure for designing, collecting and analyzing data. On a philosophical level, the study combines both objectivist and subjectivist approaches through both quantitative and qualitative methods of data collection. The interviews offer subjective responses while the themes enable an objective analysis of those responses. The methodology examines how information for the study will be collected by the researcher and how this is beneficial or limiting to understanding the topic and answering the research questions.

It has been stressed throughout the paper that the researcher will be conducting a case study in order to concentrate the information received from the literature review and other material within a confined setting. The Grace City Baptist Church was used for this study and is a suitable choice due to its size, management structure and background. A case study approach is easy to apply in a different environment should further studies on the topic be conducted.

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[36]*Data Protection Act*. The Stationery Office, London, 1998, 1-3.

The methodology section also outlines the appropriate ways in which the researcher can obtain, secure and utilize data collected so as to ensure the safety of respondents, protect their privacy and uphold confidentiality. The researcher obtained consent from participants and will protect their rights within the guidance of the Data Protection Act of 1998. Additionally, all the necessary measures required will be taken to ensure data is accurate and up to date with the requirements of the study.

Chapter 2 outlined the research design for conducting the study on the causes and impacts of depression in pastors. The steps are the research methodology, data collection method, data sample background, research questions and hypotheses, ethical considerations, summary of methodology, instrumentation and assumptions and limitations. Chapter 3 will report the findings resulting from the prescribed step followed in Chapter 2.

CHAPTER 3

FINDINGS

The purpose of this chapter is to present the findings of the study. The chapter includes a restatement of t6he problem of this study, the related hypotheses to be tested, the procedures for testing the hypotheses, and the findings of the study.

The problem in this study focused on the causes and impact of depression in pastors and what they are to do when they are struggling with personal issues such as depression, stress and burnout. This chapter also addresses the researched questions and tests subsequent hypotheses.

Research Questions and Hypotheses

There were four distinct research questions and a variety of hypotheses in the course of the study that stemmed from the literature which ultimately reflect the responses of participants. These questions guided the study and enabled the researcher to conceptualize depression outside the confines of clinical descriptions and expectations. The following research questions were answered and the related hypotheses tested.

Research Question 1. Do pastors have an understanding of the causes of depression and how do they vary for pastors?

Null hypothesis: Because they have spiritual backing, the causes of depression in pastors are different from conventional causes of depression. Pastors are unlikely to feel like other people because of their elevated position in the societies they serve.

Alternate hypothesis: The causes of depression in pastors are similar to those in other people. As seen in much of the literature in Chapter 2, similarities occur not only in causes; they can also be seen in physical, psychological and mental symptoms.

Research Question 2. How do the lifestyles of pastors and their work make them susceptible to depression?

Hypothesis: The lifestyles of pastors make them susceptible to depression because of the high expectations placed on them during service as well as within the community. The literature review section offers extensive evidence demonstrating a correlation between suicidal depression in pastors and their lifestyles as well as work.

Research Question 3. Are pastors willing to admit to the fact that they are depressed?

Null hypothesis: Pastors are not willing to admit that they are depressed because they fear stigma and retribution from clergy members as well as the public. In addition, pastors are not willing to admit that they are depressed because of their inability to assess whether they or other members of the clergy suffer from depression.

Alternate hypothesis: Pastors are willing and able to admit to depression because they have developed a better understanding of its causes. Furthermore, they are able to receive more support from the clergy and pastoral community once they come forward with their admission. They also encourage other members of the pastoral community to openly discuss depression and find means of managing the health issue.

Research Question 4. Are pastors willing to seek professional assistance when dealing with depression?

Null hypothesis: Education, training, years of pastoral ministry and the size of the clergy has little influence over the choice of pastors to choose professional assistance to deal with depression. In fact, their spirituality keeps them from seeking professional assistance as they believe it goes against Biblical teachings and the principles of the pastoral community.

Alternative hypothesis: Education, training and years of pastoral ministry have a positive influence on the choice to seek professional assistance for suicidal depression. It increases exposure to mental health issues, giving pastors a greater understanding of the need to seek assistance from people capable of helping them to appropriately deal with depression.

Secondary null hypothesis: Attitudes towards mental health issues coupled with the perception of professional guidance counselors have an impact on the pastoral community's

use of professional assistance. Because of their non-affiliation with the church, pastors are unlikely to seek help from medical professionals.

Secondary alternative hypothesis: There is increasing evidence of pastors seeking assistance from professional guidance counselors who are affiliated with their beliefs. It reduces conflict that pastors may feel relating to the principles of the pastoral community and increases their confidence on the ability of professional assistance to address their issues appropriately.

The study includes measures and established procedures for the purpose of implementation. The instrument to be used in this study is divided into three sections. The first section contains a demographic questionnaire that asked participants to provide background information about themselves such as gender, race, level of education, marital status, experience in counseling, years involved in the ministry and their affiliation with Grace City Baptist Church. The background information contextualizes the backgrounds of the respondents without compromising any objectivity on the researcher's part on how this information is pertinent to the remaining two sections of the study instrument. The section highlights how demographics may affect or correlate with responses from participants in relation to information from the literature review.

The second section of the study instrument contains thirty opinion statements adopted from Larson and later revised by Lamberton and Azlin, after which they were modified to fit the requirements of this study. These opinion statements focused specifically on the attitudes participants have towards mental health, their perceptions on the causes of depression and their level of confidence in receiving and providing assistance for depression. The third and final section of the study instrument requires participants to offer responses that highlight their attitudes towards seeking professional help when dealing with depression and their confidence in mental health professionals.

The instrument was administered as part of the case study of Grace City Baptist Church which was conducted over a three week period. Of the seventy pastors at the church, forty were willing to participate in the study, which enabled the researcher to collect a statistically significant amount of data. Prior to the study, the researcher obtained consent from the church and from each participant in the study. At this stage, the potential participants were able to review the questionnaire and understand why the study was important before deciding whether to participate. The questionnaire is designed for self-reported information, thus, the confidentiality of pastors is maintained.

The overview of the findings is presented in a chart or table format highlighting the most appropriate findings which are presented in reference to frequency level and percentages of responses. The categories, presented in the form of themes, include the respondents' demographics, interviews on coping mechanisms, the gauging of depressive behavior, and methods of intervention. Additionally, a plan of action is included providing alternative models for dealing with depression and other categories listed under mental health.

To highlight the main focus of the questionnaire, the appropriate findings were included in the chapter in tabular form and delineated a summary of the results. The entire questionnaire and the results are located in the appendices.

Results and Observations from the Survey

The researcher began analyzing the data upon receiving the results that comprised the demographic information that the participants had provided by answering the first seven questions in the interview guide. The questionnaire also outlined specific details about the participants' gender by noting whether one is male or female and depicting the participants' specific age group. Participants could, for instance, acknowledge whether they were under 25, 26-35, 36-45, 46-55, 56-70 or over 70 years of age. They could, as well, give information about their race, and marital status which includes single, married, divorced, separated or

widowed. The level of education criterion included high school, college, and bachelor's degree or graduate work. Participants were also at liberty to state whether they have graduated from college in addition to stating their employment status, years of pastoral service and their counseling training or experience. Questions that addressed demographic issues gave the researcher an awareness of the respondents' educational and personal backgrounds in a manner that kept the methods aligned with the Data Protection Act.

The results from this section of the interview are summarized in Table 3.1 as follows:

Table 3.1 Demographic Information

Demographic Information of Participants in Frequencies and Percentages

Characteristics	Frequency	Percentage
Gender		
Male	36	90
Female	4	10
Age of Respondent		
Under 25	2	5
Between 26-35	4	10
Between 36-45	12	30
Between 46-55	17	42.5
Between 56-70	5	12.5
Over 70	0	0
Marital Status		
Single	3	7.5
Married	30	80

Table 3.1 Demographic Information (continued)

Demographic Information of Participants in Frequencies and Percentages

Divorced	5	12.5
Separated	1	2.5
Widowed	1	2.5
Educational Background		
High School	3	7.5
College	12	30
Bachelor's Degree	22	55
Graduate Work or School	3	7.5
Years in Pastoral Service		
Less than 5 years	4	10
Between 5 and 10 years	8	20
Between 11 and 20 years	16	40
Between 30 and 40 years	11	27.5
More than 40	1	2.5
Counseling Training		
None	10	25
1 course	15	37.5
2-5 courses	12	30
More than 5 courses	3	7.5

The first four questions in the interview guide highlighted the respondents' personal information, while the last three questions provided information about their career and educational choices. An interesting pattern was observed with regard to the responses. The

pastors who were interviewed represent a conservative community of individuals; approximately seventy-five percent stated that they are married and ninety percent of the total respondents were male. The participants' demographic results were therefore primarily homogenous, projecting a small degree of diversity in pastors at the Grace City Baptist Church.

The level of education among the respondents is considerably high with fifty-five percent holding bachelor degrees and eighty-five percent having post-high school education. Although many of the pastors hold at least a bachelor's degree, only thirty seven percent have taken at least one course in counseling and less than eight percent have taken more than five courses in counseling, presenting an interesting disparity. These percentages also indicate that the achievement of a bachelor's degree or matriculation in college courses doesn't necessarily prepare pastors to deal with aspects of clinical counseling interventions.

Of the forty study participants, seventeen are middle-aged and sixteen have between eleven and twenty years of experience as pastors. The level of engagement in their pastoral services also demonstrates the reason only a few have gone on to take graduate work or to attend graduate school. It also indicates why most of the pastors have not taken counseling courses. Evangelical ministry work is demanding and time-consuming. Furthermore, pastors are unlikely to take interest in counseling courses given the general perceptions of conventional counseling programs.

The remainder of the interview questions reflects the way that the respondents cope with stress, burnout, and depression. The hypothetical questions were designed to analyze the objective and the subjective facets of depression, how pastors dealt with depression and burnout incidents in addition to getting their views on suicide tendencies. The questions were direct yet impersonal to make the respondents feel comfortable with their choice of answers.

Table 3.2.1 Turning to the Bible during Depression

Who are you most likely to turn to when you have a personal or family conflict or issue?

Choices	Frequency	Percentage
Fellow Congregants	3	7.5
Senior Clergy	5	12.5
The Bible	17	42.5
Friends and Family	15	37.5
Total No. of Respondents	40	100

In Table 3.2.1, it can be seen that many respondents, forty-two percent, turned to the Bible to get through personal or domestic conflicts. After the Bible, thirty-seven percent of the respondents indicated that they would turn to friends and family. Senior clergy and fellow congregants received the lowest ratings of twelve percent and seven percent, respectively. Remarkably, most respondents would not turn to their religious leaders when dealing with personal or family conflict or issues.

Table 3.2.2 Work Schedule Concerns and Depression

Does your mate or do family members see your work schedule and pastoral role as a source of conflict and complain of insufficient quality time?

Choices	**Frequency**	**Percentage**
Often	10	25
Sometimes	23	57.5
Not at all	7	17.5
Total no. of respondents	40	100

More than half of the respondents reported that their family members or partners found that their pastoral work takes up a lot of their personal time besides being the source of some of the conflicts in their private lives. About twenty-five percent of the pastors indicated that they have heard their fellow counterparts express similar sentiments. This indicates that

pastoral work may significantly affect personal interactions between pastors and members of their families. Only seven respondents noted that their family members have had no problems with their pastoral engagement.

Table 3.2.3 Burnout Concerns

Have you felt burned out within the first five years of your ministry?

Choices	Frequency	Percentage
A few times	15	37.5
Often	12	30
Not at all	6	15
I have no idea	7	17.5
Total no. of respondents	40	100

More than thirty percent of respondents have experienced burnout incidents, while seventeen percent of the respondents have no idea if they have experienced burnout. Fifteen percent of the respondents, however, noted that they have never experienced such a feeling. It is interesting to note that four out of the six pastors who have not experienced burnout have been in the ministry for less than five years.

Table 3.2.4 Leave of Absence Option for Pastors

Have you needed to take a leave of absence from your ministry because you felt unable to meet the needs of your congregation?

Choices	Frequency	Percentage
Yes	10	25
No	26	65
I have never considered it	4	10
Total no. of respondents	40	100

The question, "Have you needed to take a leave of absence from your ministry because you felt unable to meet the needs of your congregation?" was designed to gauge whether the respondents would take leave of absence if it were extended to them. It was also framed to identify whether pastors have ever considered the possibility of such an option in their career. Though a significant number of the respondents admitted to having experienced burnouts, only four of them have never considered the possibility of taking a leave of absence. An overwhelming sixty-five percent of the clergy noted that they are not interested in taking a leave of absence as twenty-five percent stated that they would consider the option if it were to be granted.

Table 3.2.5 Family's Health and Well-Being

Have you ever felt that pastoral ministry is hazardous to your family's well-being and health?

Choices	**Frequency**	**Percentage**
Yes	10	25
No	18	45
I have not considered it	12	30
Total no. of respondents	40	100

In light of the responses from Table 3.2.5, thirty percent of the respondents have not considered the possibility that their pastoral work is hazardous to their family's well-being and health; forty-five percent of the respondents do not believe that their work poses any threat to the well-being of their domestic lives and only twenty-five percent have felt the negative implications of pastoral work on their family lives.

Table 3.2.6 Adequate Spiritual Counseling

Does Grace City Baptist Church provide adequate spiritual counselors or counseling to pastors?

Choices	Frequency	Percentage
Yes	22	55
No	12	30
Not that you are aware of	6	15
Total no. of respondents	40	100

Although more than half of the respondents felt that their church has adequate spiritual counselors and counseling services, thirty percent of the respondents refuted this claim bringing about a significant disparity. Fifteen percent of the respondents were not aware that such services are offered within the precincts of the church.

Table 3.2.7 Utilizing Spiritual Counselors

How often have you gone to see a spiritual counselor?

Choices	**Frequency**	**Percentage**
Once	14	35
More than once	18	45
Never	8	20
Total no. of respondents	40	100

Respondents demonstrate that they have frequently made use of spiritual counseling services that are provided within and outside the church. The information here correlates with that of the previous question as tabulated on 3.2.6. Out of the eight respondents who have never made use of these services, six of them may be the same respondents, in the previous table, who are unaware of the church's counseling services. It is worth noting that fort-five percent of the respondents have sought spiritual counseling services in more than one occasion.

Table 3.2.8 Continuing Pastoral Duties through Depression

Would you leave the pastorate because of your depression if you had somewhere else to go or some other vocation you could do?

Choices	Frequency	Percentage
Yes	13	32.5
No	24	60
Have never considered it	3	7.5
Total no. of respondents	40	100

An overwhelming sixty percent of respondents would not leave the pastorate if they were depressed or if they had a chance to secure employment in a different field. Slightly more than half of this figure, however, stated that they would consider the option if given a chance to do so and three of the respondents asserted that they have never considered such a possibility. It is worth observing, though, that there is a strong correlation between the response to this question and the tabulation on Table 3.2.4 since twenty pastors in that table indicated that they would not take a leave of absence. Similarly, in this Table, twenty-four of the respondents would not change their careers, even if the evangelical work gave them depression and sprees of burnout.

Table 3.2.9 Stress Frequency

How often have you experienced severe stress causing anguish, worry, bewilderment, anger, depression, fear, and alienation?

Choices	Frequency	Percentage
Once	15	37.5
More than once	18	45
Never	7	17.5
Total no. of respondents	40	100

More than forty percent of respondents noted that they frequently experience bouts of stress coupled with depression symptoms. A close thirty-seven percent of the respondents reported that they experience stress-related complications once in a while. In table 3.2.3, thirty-seven percent of respondents have felt burned out "a few times." These statistics are worth comparing with the number of pastors who have sought spiritual counseling in table 3.2.7, where fourteen respondents have sought this form of assistance at least once.

Table 3.2.10 Coping with Stress

What enables you to cope best with the stress of ministry work?

Choices	Frequency	Percentage
Reading the Bible	12	30
Talking to peers and fellow congregations	6	15
Reflecting	7	17.5
Talking to family members	15	37.5
Total no. of respondents	40	100

Like the question that's tabulated in table 3.2.1, responses to this question highlighted that a large number of pastors, thirty-seven percent, sought the counsel of family members to deal with stressing situations. The second highest set accounts for thirty percent of the pastors

who cope with stress by reading the bible as indicated in table 3.2.1. Only seven respondents talked to their peers and fellow worshippers to reflect on stressing moments in their professional and personal lives. These respondents demonstrate that they have little faith in their peers a matter that drives them to open up to fellow congregations, perhaps because of their position in the church.

Table 3.2.11 Pressures of Perfection

Do you feel under pressure to have a perfect family and character?

Choices	Frequency	Percentage
Sometimes	15	37.5
Never	6	15
Not often	9	22.5
Total no. of respondents	40	100

An overwhelming majority of respondents, thirty-seven percent, sometimes experience pressure because of their personal need to have a perfect family or to portray outstanding character and personal values. Almost twenty-three percent of the respondents do not, on the other hand, feel similar pressure. Six of the respondents underscored that they are never pressured in the same way. This can be attributed to the individual pastor's marital status, age and social positions. The six respondents who admit to being under this kind of pressure correlate with the number of single, widowed and separated pastors who were part of the study.

Table 3.2.12 Religious Beliefs and Suicide

What would keep you from committing suicide?

Choices	Frequency	Percentage
Fear of condemnation	12	30
Perception of peers and fellow worshippers	8	20
Religious belief	20	50
Total no. of respondents	40	100

Exactly half of the forty respondents felt that their religious beliefs would steer them away from thoughts of committing suicide irrespective of the difficulties they may be facing in life. Thirty percent of the pastors noted that they would not commit suicide for fear of condemnation and spiritual reasons. Eight of the interviewees were more mindful about their peers' perception of and that of their fellow worshippers, which demonstrates the influence and the exertion of external forces in such personal decisions.

The interview also had a survey section which sought to capture how the respondents gauged themes regarding depressive behavior and methods of intervention. The themes included "Attitudes toward mental health," "Causes of Depression," and "Perceived Self-Competency." These were measured on a 5-point Likert scale and the respondents were offered multiple choices:

a) Strongly agree.

b) Partly agree.

c) Not sure.

d) Partly disagree.

e) Strongly disagree.

The final two themes, '"Recognition of Need for Help" and "Confidence in Mental Health Professionals" were measured on a 4-point Likert scale and the respondents were offered four choices as follows:

a) Agrees

b) Partly Agrees

c) Partly Disagrees

d) Strongly Disagrees

Note that the scale of judgment that was used in this is instance was designed by Larson[38] to measure the attitudes of pastors toward mental health issues. Each theme was tabulated against opinion statements.

Attitudes of Respondents Gauging of Depressive Behavior

Table 3.3.1 *Attitudes towards Mental Health (Entire Table 3.3.1 in Appendix D*)

Attitude(s)	Response Level	Frequency	Percentages
Mental health practitioners are very competent	Strongly agree	32	80
	Other	8	20
More odd-balls in psychiatry than other professions	Strongly agree	29	72.5
	Other	11	27.5
Clergy handle majority of emotional disturbances	Strongly agree	27	67.5
	Other	13	32.5
Greatly impressed by the results of psychiatric treatment	Strongly Disagree	27	67.5
	Other	13	32.5
Mental health practitioners overemphasize the sexual aspects of life as a cause of mental disorder	Strongly agree	25	62.5
	Other	15	37.5
Mental health practitioners' attitudes toward patient and his problem mostly positive	Strongly Disagree	21	52.5
	Other	19	47.5

[38]Larson, McCullough. *Psychotherapy with Mainline Protestants: Lutheran, Presbyterian, Episcopal/Anglican and Methodist*, Handbook of Psychotherapy and Religious Diversity, 2015.

Table 3.3.1 highlights various aspects that touch on the respondents' attitudes towards mental health issues. It also shows that most of the pastors had negative views regarding the survey. Their perception of mental health problems, how to deal the issues appropriately and their opinions on psychiatric help were also negative. A significant number of the respondents had little or no trust in mental health practitioners as close to seventy-two percent of them noted that there are more "odd balls" in psychiatry than in any other profession. Although eight percent of the respondents strongly agreed that mental health practitioners are competent professionals, more than 6 percent of them believed that emotional disturbances should be handled by clergymen, a matter that highlights their subliminal trust in mental health practitioners. It, on the other hand, shows their preference for spiritual ways of dealing with mental complications.

The mistrust of mental health practitioners can also be seen in responses to other parts of the survey. Over six percent of the respondents either strongly or partly agreed that the work of a psychiatrist conflicts with that of a pastor. More than six percent are not impressed by the developments within the psychiatric profession over the years. More than half of the respondents strongly disagreed that psychiatrists project the right attitude toward their clients during treatment. This can be pegged to the overwhelming perception that mental health practitioners overemphasize sexuality when treating mental disorders. The pastors also believed that they might violate professional ethics standards when handling mentally impaired clients. From these figures it can be discerned that the respondents prefer consulting fellow clergymen to medical professionals, despite noting that psychiatrists are competent medical professionals.

The following table indicates the highest ranking of causes of depression by the respondents. The complete table is shown in the appendix.

Table 3.3.2
Causes of Depression (Entire Table 3.3.2 in Appendix E)

Causes	Response Level	Frequency	Percentages
Lack of religious belief	Strongly agree	32	80
	Other	8	20
Excessive drug or alcohol use	Strongly agree	26	65
	Other	14	35
Self-pleasure and/or sexual habits	Strongly agree	26	65
	Other	14	35
Loneliness or isolation	Strongly agree	24	60
	Other	16	40
Demonic influence	Strongly agree	23	57.5
	Other	17	42.5
A run-down physical condition	Strongly agree	20	50
	Other	20	50

Table 3.3.2 shows that a majority of the respondents have conservative views concerning depression. They are able to associate loneliness, stress, work related problems, self-pleasure and/or sexual habits, alcoholism and physical challenges to factors that bring on depression. However, the pastors do not perceive these as symptomatic responses to depressive syndromes. About sixty-five percent of the respondents held the notion that the use of drugs and alcohol causes depression as twenty-four of forty respondents strongly agreed that loneliness causes depression; one less the number of people who concurred with the belief that demonic influence can cause depression. Another 30 percent of the respondents partly agreed that ‘trouble adjusting to the job’ can cause depression. Over forty percent of the pastors who participated in the survey conversely identify stress as one of the causal factors of depression. Close to fifty percent of the respondents on their part agreed that ‘a run-down physical condition’ is a cause rather than a symptomatic expression of depression

as sixty-five percent of them agreed that self-pleasure and sexual habits can also cause depression.

It is interesting to note that more than eight percent of the study participants disagreed with the statement that family and/or domestic disputes can cause depression. This correlates with earlier information that family members tend not to be confidants, therefore, they cannot help pastors deal with issues of depression. All of the forty respondents strongly or partly agreed that lack of religious belief is a cause of depression. Only five percent of the respondents strongly disagree with the statement that 'depression is a hereditary condition.

The table below indicates the highest ranking of perceived self-competency by respondents.

Table 3.3.3

Perceived Self-Competency (Entire Table 3.3.3 in Appendix F)

Self-Competency	Response Level	Frequency	Percentages
Training and experience enable me to feel competent to take most cases of depression	Strongly agree Other	17 23	80 20
Background severely limits much success with depressed congregations	Strongly disagree Other	17 23	42.5 57.5
Feels competent and comfortable in talking with congregation about their personal problems	Strongly agree Other	15 25	37.5 62.5
Do not know what to do for many in depressed congregation	Partly agree Other	15 25	37.5 62.5
Adequate training and experience enable me to handle depressed congregation	Strongly agree Other	15 25	37.5 62.5
Possess good understanding on how to help depressed congregations	Partly agree Other	15 25	37.5 62.5

Many of the participants in the survey appeared to have high levels of confidence in the congregation's ability to handle depression since twenty-five percent of them strongly

agreed that they were confident enough about their capacity to take care of the depressed members of their church. This correlates with their understanding of how to help depressed congregations. Consequently, twelve of the forty respondents strongly agreed with the statement that they had a good understanding of how to help depressed congregations.

Interestingly, forty-two percent of the respondents felt that their backgrounds facilitate their ability to deal with depressed worshippers. None of the respondents felt that their training was inadequate even though it was shown earlier that only a small percentage had taken more than one counseling course during their pastoral training. In fact, twelve and fourteen respondents strongly and partly agreed, respectively, that they could adequately assist depressed congregations, meaning that they did not feel as though depressed worshippers had overwhelming needs or requirements, given their level of sensitivity about the condition. Only three respondents admitted to having insufficient background to deal with depressed worshippers. Nearly thirty-seven percent agreed that they were competent enough to talk openly with congregations with depression related problems.

The table listed below indicates the extent pastors recognize the need for help. The complete questionnaire is listed in the appendices.

Table 3.3.4

Recognition of the need for help (Entire Table 3.3.4 in Appendix G)

Recognition Factors	Response Level	Frequency	Percentages
Doubtful value of involvement in professional help because of time an expense	Agree	23	57.5
	Other	17	42.5
Personal and emotional trouble tend to work out by themselves	Agree	21	52.5
	Other	19	47.5
Seek professional help for long period of time of depression	Strongly disagree	20	50
		20	
	Other		50
Works on his or her own problems. Getting professional help would be a last resort	Agree	19	47.5
	Other	21	52.5

About forty-two percent of the respondents found it admirable for a person to endure depression without seeking clinical treatment or intervention for a prolonged period of time. In fact, twenty of the forty respondents admitted that they would not want to seek clinical treatment when depressed. About thirty percent of the respondents nonetheless agreed that they might want to seek professional treatment in the future, meaning that they were open to the possibility even though they would not necessarily utilize it. This may have to do with the perceived cost of psychiatric therapy. More than half of the respondents agreed that the cost and time spent on the therapy are too high for mental problems that can be sorted out through other means. In light of these views, a little more than half of the participants believed that personal or emotional problems tend to work themselves out, which correlates with the nineteen respondents who felt that personal problems should be handled at an individual level, making the bid to seek professional help less paramount among the pastors, whenever they get depressed.

The following table indicates a summary of the results of the respondents' confidence level in mental health professionals. The entire questionnaire is located in the Appendices

Table 3.3.5

Confidence in Mental Health Professionals (Entire Table 3.3.5 in Appendix H)

Confidence Level	Response Level	Frequency	Percentages
If depressed, my first inclination would be to get professional attention	Partly disagree	20	50
	Other	20	50
Serious depression currently would cause me to be confident to find relief in professional help	Partly disagree	17	42.5
	Other	23	57.5
A person with depression is not likely to get better alone, he or she is likely to get better with professional help	Agree	17	42.5
	Other	23	57.5
Treatment by a mental health professional is a poor way to get rid of emotional conflict	Partly disagree	12	30
	Other	28	70

The results from this table represent an interesting contrast from the information collected in the preceding tables. There is an increase in the level of confidence that the respondents have in professional help, although not many of them admit that they would seek professional assistance. Over forty percent agree that one is better off seeking professional help than coping with depression alone as a similar percentage partly disagrees that they would seek assistance when in a depressive situation. Nevertheless, 30 percent note that they would seek professional help should they experience severe depressive symptoms.

Summary of Results

A correlation of all the information gathered in the tables demonstrates that the respondents have conservative views when it comes to stress disorders and how to handle them. They lay a great deal of emphasis on turning to clergymen, congregations, and members of one's family as a way of coping with stress and other issues that relate to depression. While the respondents could associate loneliness, alcoholism, drug abuse, stress and inability to cope with work to depression, they perceived the above elements as causal factors rather than "stress-coping" mechanisms, especially when talking of alcoholism and drug use.

Factors that affect the perception of the respondents include their demographics, their professional, academic, and social backgrounds in addition to their inclination toward pastoral practice. Many of them were skeptical about seeking intervention from mental health practitioners and even expressed admiration for individuals who have wriggled through stress related issues without seeking medical professional help. If this is the case, then consideration is important for the development of models for the intervention and prevention of mental health for pastors.

Models for Caring for Pastors with Depression

The road to finding a solution to a problem may encounter many twists and turns. Pastors suffering from depression may opt to travel down a new path in order to survive in their chosen life's work. One of the paths includes the use of models that have achieved some level of success for pastors enthralled in personal crises. Two such models are C.A.R.E. (Counseling, Affirm, Resource and Equip) and the Seminary model.

The use of a particular model is not always the ultimate solution to a given problem. The model can serve as a tool to study extended implications of a problem by utilizing a systematic approach. Employing a systematic approach has the possibility of providing enough details that the desired solution obtained will be of value for the problems studied.

The assumption of the value of the model can be determined by testing the validity of the model. The proposed C.A.R.E. and Seminary models have certain principles to guide them.

Principles of the C.A.R.E Model

Counsel

As observed, the acronym CARE stands for Counsel, Affirm, Resource and Equip. Within the first principle, Counsel, pastors are given spiritual wisdom in the form of spiritual, lay and ministerial counseling. Counsel is important in restoring spiritual faith and offering nourishment through spirituality. Hughes argues that, as a basic requirement, local churches must have in place a counseling program that is accessible and useful to pastors.[39] As observed in the results of the study, the pastors who responded were more comfortable with seeking solutions to depression from the church and from a spiritual perspective. As an example, Livingston et. al. note the use of Counsel in processing groups. One such example is Fresh Start, which helps individuals deal with forgiveness.[40] Similarly, Counsel can be used in groups that come together to deal with depression.

Within this principle of Counsel, churches can adopt a variety of counseling models that borrow from spiritual, lay/professional and ministerial teachings. These resources are widely available in church literature, especially those written by experienced members of the church, according to the principles of their congregation and that of the pastors they are counseling.[41] Each intervention model comes with its own methodology and philosophy, which pastors should be wary of when adopting them into their

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[39]Hughes, "Shepherding the Flock," 51.

[40]B. E. Livingston, K.M., Myers, M.R. Jordan, B.S., Jelinek and A. Pumley, "Pastoral Formation Process for Seminars," 4.

[41]Hughes, "Shepherding the Flock," 51.

situations.[42] Churches can choose either a spiritual/ministerial or a professional model or combine both to care for pastors dealing with depression.

Professional/Lay Counseling

Professional counseling is widely available and is a more conventional approach to dealing with depression. Hughes suggests that, given the wide range of traditional and bizarre forms of therapy, pastors should first seek "competent Christian counselors."[43] Some churches may have on-site professional counselors from which pastors can benefit. One of the advantages of an on-site professional counselor is that it provides ease of access to clergy members. Livingston et. al. also observe that when churches are hiring a counselor, philosophical, ideological, and methodological beliefs are also probed to ensure that the counselor's inclinations are similar to those of the relevant church.[44] Furthermore, the church underwrites all the costs of the on-site counselor, which works to the advantage of pastors who make use of their services.

For this reason, platforms such as the Christian Care Network (CCN), accessed through the American Association of Christian Counselors, offer pastors a referral network to state-licensed, certified clinicians with a Christian background.[45] As a national referral network, pastors can find counselors almost anywhere within their geographical area and access their profile to determine if the counselor's philosophical, theological and methodological inclinations match those of the pastor's and the church they serve.

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[42]Jay Edward Adams, *Competent to Counsel: Introduction to Non-authentic Counseling* (Grand Rapids, MI: Ministry Resources Library, 1986): 100.

[43]Hughes, "Shepherding the Flock," 52.

[44]B.E. Livingston, K.M., Myers, M.R. Jordan, B.S. Jelinek and A. Pumley, "Pastoral Formation Process for Seminaries," 4.

Sandra Miskelly, "A Parish Nursing Model: Applying Community Health Nursing Process in a Church Community," *Journal of Community Health Nursing* 12(1995): 7.

Such a platform is essential should a pastor opt to deal with personal or private problems more confidentially.

Ministerial/Spiritual Counseling

In a majority of cases, pastors prefer to undergo ministerial counseling. Ministerial counseling is often perceived to be an exclusive realm of the church that is solely administered by a minister or pastor. However, it can also borrow from the principles of professional counseling and incorporate some of its methodologies. How does a pastor ascertain that they are receiving good quality ministerial and spiritual counseling? Unlike professional counseling that has academic and professional accreditation, the measure of spiritual counseling is intangible. Nevertheless, pastors can utilize guides and resources to get the most appropriate spiritual counseling experience.[46]

Hughes observes that many pastors begin their career by taking pastoral care and counseling courses in the course of training or even in their earlier education.[47] During their ministerial service, pastors are also able to take counseling courses outside their seminary education. These come in the form of training DVDs, books, workshops and websites that provide a great deal of meaningful information. However, not all of these resources are useful and not all of them meet a high criterion. For this reason, Hughes provides a comprehensive list of resources, some of which are selected here, for pastors to make use of in their own ministerial counseling for depression.[48] Among the books Hughes suggests, he is especially

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[46]Thom S. Rainer, *Surprising Insights from the Unchurches and Proven Ways to Reach them*. (Chicago: Moody Press, 2002): 72.

[47]Hughes, "Shepherding the Flock," 53.

[48]Ibid.

keen on those that offer "counseling from a biblical perspective."[49] This is because such counseling places emphasis on the character of the counselor, offers foundational understandings of core principles that counselors deal with and the contrasts between secular and spiritual counseling. Two books that are strongly recommended that offer inspired information to pastors are Jay Adams' *Handbook of Church Discipline* and Randall P. Pope's, *The Prevailing Church: an Alternative Approach to Ministry*, which is a step-by-step counseling guide.[50]

The use of media resources, such as training and workshops, are also an essential strategy to the development of skills in ministerial counseling. One example is the *KLS LifeChange Ministry*, which offers both online and conference training.[51] The online portion includes readings of a variety of texts including those recommended by Hughes in the previous paragraph. The ministerial counseling sessions cover a variety of personal and spiritual topics, including stress, trauma, parenting and marriage. They are offered in the form of workshops, which Hughes notes are a "cost-effective way to prepare for pastoral care issues" and are applicable while offering ease depending on a pastor's setting.[52]

Affirm

After counseling, pastors need comfort and support through life's trials. Hughes argues that pastors need to experience comfort from the body of Christ as in 2 Corinthians 1:4. [53]

Ibid, 54.

Jay Adams, *Competent to Counsel* (Grand Rapids: Zondervan Publishing House, 1986).Randall P. Pope, *The Prevailing Church: an Alternative Approach to Ministry* (Grand Rapids: Baker Books, 2006).

Henry Brandt and Kelly L. Skinner, *The Word of the Wise,* 2nd ed. (Mobile, AL: KLS LifeChange Ministries, 2008): 90.

Hughes, "Shepherding the Flock," 55-56.

Ibid, 64.

Affirmation enables pastors to deal with a variety of issues, many of which are related to depression, such as bereavement, hospitalization and spiritual crisis resolution. Hughes observes that affirmation is especially instrumental for crisis resolution, bereavement and loss because it enables a rich connection with the church community, something that is needed especially when pastors are grappling with depression.[54] Affirmation can be provided through two processes, namely Stephen Ministry and Prayer. Overall, these two modes of affirmation enable pastors to form a connection with God more than just as a means of dealing with the problem; however, the most relevant mode for this paper is Stephen Ministry.

Stephen Ministry is a tool currently in use in more than 11,000 churches across the United States and involves caring for the needs of others.[55] In addition to counseling, Stephen Ministry involves management of crisis and development of skills with the assistance of care givers trained by the ministry. The organization derives its name from Stephen in the Book of Acts' sixth chapter, where Stephen provides service on an individual basis to people in need both within and outside the church structure.[56]

Stephen Ministry is a more informal set up and can be administered frequently or on a need-to basis, such as making contact with an individual an hour every week or whenever there is an emergency.[57] There is no set limit on the duration an individual takes on this mode of affirmation and the flexibility enables the establishment of strong, spiritual relationships. Stephen Ministry encourages prayer and ensures confidentiality for a pastor or church

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[54]Hughes, "Shepherding the Flock," 72.

[55]Stephenministry.org

[56]Ibid.

[57]Ibid

member seeking assistance from them. Although it is not a formal counseling position, Stephen Ministry receives training to prepare them for their capacity. Training includes 50 hours of workshop, which include reading spiritual texts and material and practicing the role of a caregiver in a variety of situations.[58]

Resources

Resources enable pastors to have tools that meet current and ongoing needs when dealing with depression. Hughes cites five elements that encompass the resources that pastors can use; support groups, counselor referrals, prayer, military ministry and benevolence.[59] Resources allow pastors to take advantage of preventative methods of dealing with more severe effects of depression, while also safeguarding other members from being adversely affected by the same. Hughes observes that many churches have developed programs, such as lay counseling and biblical discipleship ministries, as preventative methods of dealing with crises among pastors and worshippers.[60]

Some churches also establish counseling referral networks. Churches do this by determining the types of counselors available and linking their practices with the philosophies of the church. The counselor's practice should in no way divert from the requirements of Scripture. As noted earlier in Counsel, the first principle of C.A.RE, a way of managing this is in having an on-site church counselor who has been adequately vetted by the church for their services or making use of CCN to identify a suitable counselor.[61]

Hughes, "Shepherding the Flock," 76.

Ibid, 80.

Ibid.

Miskelly, "A Parish Nursing Model: Applying Community Health Nursing Process," 8.

The screening process for a suitable counselor involves a considerable number of factors, such as the testimony of the counselor, their current involvement in the church, their ability to share Christ with an individual, and their balance of theological views with their counseling practice. Additionally, the church scrutinizes educational and professional qualifications, accreditation, the status of their licenses and the counselor's specialty. They contact relevant references, conduct interviews with the counselors and review the application. Once approved, the counselor is taken by the church or placed on their referral list.[62]

Once the counselor is placed on the referral list, a church can set up a support and recovery group for members dealing with depression. The group should have a leadership structure and be able to provide resources and deal with the challenges of ministering to participants. Most importantly, they should provide care in an accepting environment.[63] The best support groups are those that have live meetings, although they can also take different forms such as online groups and discussion formats. One of the values of support groups is that it brings together individuals with shared experiences, which reduces stigma and enhances the credibility of solutions from people who have similar experiences.

Through the members in the support group, churches can instill a culture of benevolence through prayer and military ministry. Hughes observes that people in need "provide a ripe opportunity for sharing the gospel."[64] It becomes a means of returning

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[62] Miskelly, "A Parish Nursing Model: Applying Community Health Nursing Process," 8.

[63]Hughes, "Shepherding the Flock," 82.

[64]Ibid, 86.

service to a community that has nurtured pastors through trying times and of keeping the pastors engaged within their surrounding community. Benevolence may at times require financial power; however, churches can easily determine how much of their financial resources they are willing to put in to provide counseling services.

Equip

The final principle in the CARE model is Equip. In this phase, pastors are trained to meet their own pastoral care needs as well as those of their community and church members. It includes aspects of Stephen Ministry, Bible discipleship counseling, spiritual coaching and lay counseling preparation. The Equip component is both basic and specialized, according to the needs and interests of pastors. The training offered is close to professional standard and pastors can use it on themselves and as a way of helping others in similar situations, which makes it wholesome and preventative.

Initial training for Stephen Ministry takes a total of 50 hours and includes 25, three and one-half hour modules done over the course of four or five months. The meetings for each module are weekly, conducted by qualified course leaders who have undergone similar training. It is an interactive course that includes brief lectures, discussions, role-play situations and a variation of instructional methods.[65] The sessions allow for pre-class readings for both trainers and trainees so that they have a sense of the material they are going to cover and are adequately prepared. It also saves time when administering modules.

The reading and the topics are distinctively on Christian caregiving, assertiveness and referrals to church-accredited mental health practitioners. Stephen ministers are assigned groups to supervise once the course has been completed and after they have completed the

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[65]Hughes, "Shepherding the Flock," 88.

requirement of twelve hours of continuing education each year. This keeps them constantly equipped with relevant information for emerging counseling requirements. Training and supervision may also be in conjunction with lay or professional counselors and experts from outside the church.[66] Nevertheless, the material is carefully examined to ensure it adheres with the principles, philosophies and theological expectations of the relevant church.

Consequently, churches can equip pastors with biblical discipleship. One example offered by Hughes is Johnson Ferry Baptist Church's lay biblical discipleship program.[67] Although it is expected that pastors already have adequate knowledge of the Bible and can turn to it when in spiritual need or when seeking spiritual solutions to depression, it is refreshing to take a course, not as a pastor, but as an individual dealing with depression. The program involves lectures, discussions and role-playing and is approximately a year long, with weekly meetings for two hours each session. At the completion of training, participants receive biblical counseling supervision from ministers and volunteer staff attached to the church.[68]

Other training sessions include intensive writing assignments, journaling and life coaching sessions under the guidance of ministerial supervisors. Such training is commendable since it is hands-on and is an effective way of equipping pastors.[69] Foundational training on biblical counseling is also covered to enhance familiarity with the Bible and aptly apply it to cases of depression in pastors. One of the rewarding elements of

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[66] Stephen Ministry, *Stephen Ministry Training Manual* (St. Louis, MO: Stephen Ministries, 2000), 17.

[67]Hughes, "Shepherding the Flock," 88.

[68]Adams, *Competent to Counsel*, 24.

[69]Ibid.

this training is that it teaches pastors how to deal with dynamic problems that they or members of their community encounter.[70] Role playing also gives them perspective, while journaling allows them to keep a sequenced account of ways they are improving, keeping track of the progress they have made in dealing with depression.

Supervision in Stephen Ministry ensures excellence and quality control. It also enables individuals to work in small, manageable groups that enhance individual attention, care and healing. After the group time, the final step requires debriefing, where leaders and participants discuss the outcomes of the program and ask, and answer, questions from one another. Debriefing keeps communication among members of the group open and ensures that there is a continuous support system available for members.[71]

Principles of the Seminary Model

Based on the results of this study on depression in pastors, the researcher believes that pastors are not adequately prepared through their seminary education and past education to adequately deal with issues pertaining to depression. Typically, higher learning institutions and seminaries tend to offer fewer than five courses in pastoral care. In fact, on average, from the survey of the study, less than twenty percent of the respondents had taken the maximum number of five courses on counseling, although all of the respondents had taken at least a course, which meant that they were at least aware if not conversant.

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[70]Henry Cloud and John Townsend, *Making Small Groups Work* (Grand Rapids: Zondervan Publishing House, 2003), 68.

[71]Cloud and Townsend, *Making Small Groups Work*, 72.

Benevolence

Seminary courses on benevolence need to enable students and soon-to-be pastors to develop a philosophy of giving and helping within reason. Benevolence is a core concept in seminary studies and in the pastoral practice as it offers a foundation for empathy and understanding. In fact, Tim Keller believes that it should be the first topic to be covered in seminary courses.[72] There are various types of benevolence offered, from tangible things such as food, clothing and financial assistance to other forms of benevolence such as a listening ear. In the courses, students are taught how to draw guidelines on how to help, for what duration of time and the financial costs that may be incurred when giving assistance. The students then develop a benevolence plan for a church they are attached to for consideration.[73]

The benevolence plan includes information that enables students to discern the needs of an individual or community they are assisting, which Hughes observes is an exercise that requires some degree of role-playing.[74] For instance, when assisting an individual, the student must collect information such as their demographics, income data, financial need and current resources among other things. The student then matches this information with the resources available at the church to see how best to assist the individual. It also enables the church to counsel individuals in need according to their resource availability and affordability.[75]

Counseling and Counseling Referrals

As observed in the church model for approaching depression, pastors must be taught how to seek assistance from Christian counselors and how to determine whether the

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[72]Keller, "Four Models for Counseling," 2.

[73]Keller, "Four Models of Counseling", 9.

[74]Ibid.

[75]Ibid.

philosophical, methodological and theological inclinations of the counselor match those of their beliefs. Pastors should be taught how to contact counselors and have follow-up systems when keeping in touch with counselors. Most importantly, they are taught to develop a screening process to determine the suitability of a counselor on their case, one that is effective and supportive of their church values.[76]

Hughes suggests that churches take advantage of counseling and counseling referrals training in seminaries by establishing support groups that serve as a type of counseling and care group. From such sessions, students and would-be pastors would discuss counseling strategies such as how to sustain the benefits of counseling. The group would be taught the importance of leadership, distribution and use of resources, dealing with challenges and ministering over pastors in need of care when faced with depression. A well-fitting class project that can be undertaken for a better understanding of the topic is a visit to a support group to observe its characteristics.[77]

In doing so, counseling and counseling referrals become a proactive aspect of seminary courses. Ministers can come up with preventative measures and intervention strategies that offer the best outcome for pastors dealing with depression. Class time can be spent conducting research on the topic and then field practicum could be conducted in the form of workshops. Counseling and counseling referral is beneficial when preparing pastors for lay or ministerial counseling.[78]

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[76]Miskelly, "A Parish Nursing Model: Applying Community Health Nursing Process," 8.

[77] Hughes, "Shepherding the Flock," 93.

[78]Ibid.

Bereavement

Bereavement is one of the prevailing causes of depression in pastors as seen in some of the earlier examples in this study on pastors dealing with depression. Ministers should be equipped to deal with the loss of family, friends, loved ones and even fellow members of the clergy. Seminary courses in bereavement enable pastors to have a rich connection with members of the church and the philosophies of the church environment. One of the core concepts in the topic is the ability to give and gain comfort and support from the church structure.[79]

Bereavement teaches leadership and encompasses elements of benevolence. Students learn how to prepare church services for bereaved individuals. Preparation includes organizing the message, determining protocol to be followed during the service, making home visits and presenting funeral messages for evaluation. Following this preparation, students should be in a position to offer aftercare services to bereaved individuals and their families. Students come up with plans that they believe are suitable depending on the needs of an individual and/or their family. Aftercare takes place for a period determined by the student based on their interaction with the individual.[80]

Spiritual Crisis and Crisis Management

Depression represents both a spiritual and personal crisis for pastors experiencing it. This explains why there has to be a seminary course or topic on crisis management. During spiritual crisis and crisis management, pastors are required to evaluate and examine an individual's trauma. Therefore, in this segment of the course, students should be given

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[79] Stephen Ministry, *Stephen Ministry Training Guidelines,* 8.

[80] Hughes, "Shepherding the Flock," 95.

systematic methods of responding to crises. These include contacting the affected person as soon as the problem arises, assessing the severity of the problem at hand, offering appropriate solutions and responses to the situation, developing an immediate plan of action and encouraging the individual, together with their family members and close friends, to connect with God.[81]

This crisis management segment of the seminary is crucial because it requires the availability of a wide range of resources and knowledge. Resources include community-based resources, emergency housing and hospitalization, counseling on a long or short-term basis and the establishment of recovery centers and support groups. These resources are not just limited to those found outside the church and in environments that are more conventional, but to anyone who needs the services. Another essential resource that is necessary for spiritual nourishment and is available within the church structure is prayer, especially using Scripture.[82]

Churches must encourage sound prayer ministries that deal with a variety of requests and requirements. One such prayer ministry is establishing a prayer line, via telephone, post or online, that allows worshippers to log in prayer requests and even speak to members of the church about the problems they face. The church would have, on hand, volunteer staff equipped with the necessary scriptural knowledge to guide people through their prayer requests and to obtain spiritual nourishment from wherever they are. This type of arrangement enables individuals to feel closer to the church set up.[83]

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[81]Ibid.

[82]Adams, *Handbook of Church Discipline,* 42.

[83]Adams, *Handbook of Church Discipline,* 34.

Physical Needs (Illness, Disease and Hospitalization

Noted in the study is that depression is not only a mental health issue but has physical manifestations that can cause secondary problems such as illness, disease and hospitalization. Consequently, pastors in the seminary need to be prepared to deal with such eventualities. They also need to understand how to minister to the sick and how that can be used to channel to spirituality. Hughes observes that this type of provides a rich opportunity to tap into faith and make use of the elements of benevolence.[84]

Training in Lay Ministering and Counseling

The final lesson given, once all the other concepts have been covered, is the ability to offer counseling and ministerial services to those suffering from depression. In fact, training in counseling is the integral part of the seminary, since pastors are figures who are sought after during personal and spiritual crisis. Counseling should be taught in the form of a project, where students devise a learning plan on pastoral care for pastors suffering from depression. The learning plan must encompass both individual and community needs.[85]

Training should involve both basic and specialized components depending on the interests of students. In some instances, Hughes observes, churches already have specific training programs in place as part of their design.[86] The training programs are included by Stephen Ministry or other professionals and volunteers. It is important for the training offered to be hands-on in order to give students the requisite experience, when counseling, in the course of their practice.

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[84] Hughes, "Shepherding the Flock," 99.

[85] Adams, *Handbook of Church Discipline*, 88.

[86] Hughes, "Shepherding the Flock," 101.

On the other hand, the church C.A.R.E. model is a suitable institutionalized form of dealing with pastors with depression. As observed, it is made up of four components. The first component is Counsel which is the principle of pastoral care that offers pastors the spiritual wisdom to enable them get through a variety of events in their life. It may cover aspects of professional, ministerial, and lay counseling. Counsel also involves helping people undergoing spiritual crisis, establish church discipline, and includes some processing groups.

The second principle, Affirm, provides care and support in life's trials. Affirm is a proactive step that helps people through loss (bereavement, funeral planning and services, aftercare), hospitalization and illness, and crisis resolution. Such assistance is provided through ministries that offer supportive care, such as Stephen Ministry, and prayer.

A third principle, Resource, is an immediate and ongoing process of CARE. Resource includes counselors and counselor referrals, the establishment of support groups, elements of benevolence, prayer, and military ministry, which enhances church discipline.

According to Hughes, "Equip, the fourth principle, trains members in the local church to meet the pastoral care needs of the congregation and community."[87] Equip covers aspects such as training for Stephen Ministry, lay counseling/biblical discipleship, counseling preparation, spiritual coaching and training for other specific and basic ministries such as the prayer ministry, benevolence, and military ministry.

C.A.R.E. encompasses a variety of principles within the four core principles and offers a step-by-step method that gradually gives pastors a means of becoming self-sufficient using resources available to them from the churches they serve. C.A.R.E. also is an important way of bonding with members of the church community and reinforcing spirituality through prayer and the use of Scripture.

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[87]Hughes "Shepherding the Flock," 88.

Summary

The overall findings verify that in the ministerial arena, a need exists for a supportive religious community as well as the general community as a whole. Based on information gathered from research evidence and/or empirical evidence, coping mechanisms exists and intervention tools are available.

Pastors who are struggling with some form of mental health issues can answer the question of what to do by seeking a solution or solutions from the perspectives of religious, medical and/or the utilization of support models. The question now is "What can we conclude from the findings?"

Chapter 3 reported the findings resulting from the prescribed steps followed to gather the data as listed in Chapter 2. The interpretation of the data was presented. Chapter 4 will reaffirm the thesis statement, discuss the issues, and reach a decision on the plausibility of results for questions answered in the study. Additionally, the presentation of implications of the study, limitations, areas for future research and conclusions will be delineated.

CHAPTER 4

CONCLUSION

There are many challenges facing pastors today. Mental illness is a major issue that is growing at an alarming rate among pastors and other religious leaders. This study was conducted to understand the causes of depression in pastors and also to devise a plan of action that will provide alternatives to dealing with depression in a positive and healthy manner. It also assessed the factors that influence perceptions of depression in pastors, especially in relation to their demographic information and the pastoral lifestyle. The study further examined how different religions perceive depression and positive methods pastors can use when coping with depression. A case study was conducted with ministers in Grace City Baptist Church to answer the research questions. Ultimately, the intention of the study was to provide coherent and holistic care models for pastors dealing with depression. This final chapter reiterates the major points of the study, the methodology, characteristics of participants and interprets findings and examines implications for future research and consideration, especially among pastors.

Results of Research Questions and Hypotheses

There were four distinct research questions and a variety of hypotheses in the course of the study that stemmed from the literature and the responses of the participants. These questions guided the study and enabled the researcher to conceptualize depression outside the confines of clinical descriptions and expectations. The research questions and hypotheses will be full addressed in this chapter. The conclusions appear warranted based on the findings in this study.

Research Question 1: Analysis and Response

Research Question 1. Do pastors have an understanding of the causes of depression and how do they vary for pastors?

Pastors were able to identify the causes of depression beyond spirituality and were

able to relate it to their personal and professional lives. In various instances, pastors made indirect links to their lifestyles with depression and there was some hesitation in identifying these variables with depression. Research supported the facts that regarding signs and symptoms of depression.

According to Hart,[88] some of the signs of depression in pastors may include anxiety, mood swings and persistent sadness. In addition, pastors who were once vibrant may become constantly pessimistic and hopeless. Moreover, they may lose interest in ordinary activities such as spending time with the family or going to church. Depressed pastors also experience sleep disturbances, such as oversleeping, insomnia and night waking. Most importantly, they may become withdrawn and constantly harbor thoughts or even make attempts to end their lives.

Christians must learn that they are not immune to depression, according to Hart.[89] Moreover, pastors need to understand that burnout, which sometimes leads to depression is not a sign of personal failure. In most cases, clerics think that they experience burnout because they possess certain defects while in reality the burnout is triggered by the hectic and demanding work environment. Eventually, when burnout continues unchecked for an extended period of time, it leads to guilt and a sense of personal loss.

Trying to intervene to assist a depressed pastor may be difficult because of the privacy required in the role and then necessary level of confidentiality makes it difficult for an outsider who may be a professional to assist. Most traditional and mainstream religions do not allow access to their lifestyles. Additionally, it may be necessary to determine other

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[88]Archibald D. Hart, "Depressed, Stressed, and Burned Out: What's going on in My Life?" Enrichment Journal, no 23 (2015):10.

[89]Ibid.

underlying factors that would cause pastors and other religious leaders to reach a point of committing suicide.

Unlike ordinary people who can engage in more social activities that ease the burden of their daily lives, even within the social circles of pastors, very little appears to be discussed aside from difficulty with Scripture itself. There is the sense that any externalities need to be suppressed and as a result, anxiety among pastors is inadequately addressed. Perhaps amongst themselves, pastors and religious leaders should have support groups that enable members to discuss any form of difficulty they may be experiencing in order to enable early intervention in incidents of depression and to assist in easing the burden.

A comparative analysis of perceptions and causes of depression within the pastoral community helps people to understand how different religion-based entities deal with the issue. Jennifer Shepard Payne observes that within the Caucasian pastoral communities, for example, pastors are open to the idea that depression can come about as a result of biological mood disorders.[90] African American pastors, on their part hold that that depression is caused by sheer moments of weakness which they deem to be part of the day-to-day life.[91] For this reason, African American churches do not seek to understand depression through a professional approach such as deploying the services of a mental health facilitator which is deemed an irrational move that is normally strongly discouraged, if not condemned.[92] From these clipped perceptions, scholars can further note that causes of depression as perceived within the religious ministry could be different from the clinical and secular understanding of the matter.

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[90]Payne, "Variations in Pastor's Perceptions of the Etiology of Depression by Race and Religious Affiliation," 362.

[91] Ibid.

[92]Keneshia Bryant, Nancy Greer-Williams, Nathaniel Willis and Mary Hartwig, "Barriers to the Recognition and Treatment of Depression: Voices from the Rural African-American Faith Community," *Journal of National Black Nurses Association* 24(2013): 31-38.

Depression is both biological and psychological. As seen in the symptoms, depressed patients present themselves with varying physical as well as mental issues that work together to bring about the condition.[93] Typically, depression often comes about from a feeling of inadequacy or lack of self-fulfillment. It can also be caused by bad relationships, traumatic experiences and the loss of a loved one. When such factors combine with the lives that pastors live in their communities, it doubles the cause of depression as well as the effect. This explains why the rate of depression is high across the United States and relatively dominant with the pastoral community.

The School of Divinity at Duke University presents startling figures on depression and anxiety within the clergy and closely links it to job stress.[94] Depending on the length of time pastor have served their ministries, levels of depression can vary. However, the school notes that there is a high prevalence rate of depression among the middle-aged pastors in Caucasian communities, based on the responses they were able to obtain from the study that they carried out.[95]

Perhaps to understand why pastors and clergymen, especially in their later years are susceptible to depression, one element that needs to be considered is the kind of work in which they are engaged. In addition, an assessment that has to be made is one of their state of mind. Bonelli, Dew, Koenig, Rosemarin and Vasegh aptly note that the relationship between religious and spiritual practices and depression has not been sufficiently examined in academic literature, yet the two are almost mutually exclusive.[96] Clergy members are

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[93]Ibid.

[94]Ibid.

[95]Duke University, "Clergy More Likely to Suffer from Depression, Anxiety," Duke Divinity School.

[96]Bonelli, Dew, Koeing, Rosmarin and Vasegh, "Religious and Spiritual Factors in Depression: Review and Integration of Research," 1.

involved in a host of activities that affect the perception of the world and stretch their capacity to withstand the happenings of their community. Some of their duties include helping to make funeral arrangements, pre-marital counseling, handling grief, bereavement and loss, performing weddings and christening ceremonies and counseling members of the congregation.[97] The sensitive nature of their duties puts them in a delicate position, which makes them more likely to suffer from bouts of depression and anxiety.

Pastors find themselves engaging so much in the lives of others that their own well-being is neglected or not adequately addressed. Like other people in their congregation whom they assist, pastors are also faced with problems within their families and personal lives. Quoting the Clergy Health Initiative's director, Rae Jean Proeschold-Bell, the Divinity School of Duke notes that the lives of pastors are so intertwined in their church or clergy that their well-being is completely dependent on the well-being of their clergy.[98] As a result, pastors who reported great satisfaction with their ministry are less likely to have depression or anxiety. When they have no recourse to address personal issues within the clergy, then they register dissatisfaction and slump into depression.[99]

In addition to job-induced stress, Andrew Knott highlights some of the major physiological, social and psychological causes of depression among pastors.[100] He correctly observes that pastors may experience stress as a result of financial pressure, social expectations, fear of failure, mental and physical fatigue, unresolved inner issues and

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[97]Payne, "Variations in Pastor's Perceptions of the Etiology of Depression by Race and Religious Affiliation"

[98]Duke University, "Clergy More Likely to Suffer from Depression, Anxiety," Duke Divinity School.

[99]Duke University, "Clergy More Likely to Suffer from Depression, Anxiety," Duke Divinity School.

[100]Andrew Knott, "Top Ten Causes of Depression in Pastors," April 27, 2014, accessed June 24, 2015.

conflicts and frustration in their line of work especially when experiencing spiritual warfare. Knotts' observations are based on 46 years of ministry service. The vulnerability to internal conflict and a failure to resolve issues either through suppression or avoidance exacerbates depression and anxiety in pastors.[101]

Bonelli and Dew's research focuses on the intersection of religious life and depression, especially with regards to the significance of belief, degree of commitment and the amount of time pastors dedicate to religious activities.[102] They examine how spiritual warfare can be the major cause of depression among pastors. They found that, irrespective of denomination or race, pastors who are too immersed in the ministry are likely to suffer bouts of depression or anxiety that could lead to suicide. In their position as leaders in the community, pastors are more open to receive scrutiny from members of the public who may have unrealistic expectations of them or make unreasonable comparisons to them.[103]

There is a correlation between the lifestyle of pastors and the causes of depression. Externalities as a result of their environment contribute greatly to cause and effect. There is the sense that their environment causes them to suppress to their true feelings. Bryant, and Greer-Williams make an interesting observation in the responses of clergy members and pastors within African American communities.[104] When asked a question such as "How are you doing?" the generic response tends to be "blessed in the name of Jesus." Mentions of

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[101]Ibid.

[102]Bonelli, Dew, Koeing, Rosmarin & Vasegh, "Religious and Spiritual Factors in Depression: Review and Integration of Research."

[103]Givens, "Seven Issues that May Cause Depression Among Pastors."

[104]Bryant, Greer-Williams, Willis & Hartwig, "Barriers to the Recognition and Treatment of Depression: Voices from the Rural African-American Faith Community."

anxiety are met with a "shh" or a hushed tone and referred to as "demons." Depression becomes something that is caused by forces completely external to the person afflicted.[105]

It would not, however, be fair to say that spirituality is negative and that pastors should then remove themselves from living in this manner. The scholars simply argue that spirituality is not adequate to resolve issues of depression and can add to the anxiety that pastors already face. When pastors feel as through aspects of their lives are in conflict with Scripture or that Scripture does not adequately respond to their current issues, then they feel trapped and inadequate. In many church setups, pastors are discouraged from questioning Scripture and are asked to absorb it at face value.

The various stories highlighted throughout this study demonstrate that personal and private issues that pastors face, ranging from extramarital affairs to deaths in the family, to loss of sense of purpose within the ministry, are largely the cause for depression in pastors.[106] It is important for the clergy and ministry to look for ways to prevent daily problems like these from affecting the well-being of pastors and their ability to serving the community effectively.

Research Question 2: Analysis and Response

How do the lifestyles of pastors and their work make them susceptible to depressions?

The findings of the study and the literature support the hypotheses that lifestyles of pastors do make them susceptible to depression because of the high expectations placed on them during service as well as within the community. The literature review section offers extensive evidence demonstrating a correlation between suicidal depression in pastors and their lifestyles, as well as work. The literature points out that as role models in society,

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[105]Ibid.

[106]Hallowell, Billy. 2014, "'The Darkest Time of my Entire Life:" Preacher Reveals the Struggle that Nearly led to his Death" The Blaze. Accessed June 12, 2015.

pastors are often faced with difficult moral choices because expectations on them are higher than on other individuals. In an effort to lead by example, pastors heavily adhere to teachings they give to their worshippers. This means that they deal with depression by praying more, reading the Bible and working hard to memorize the Scripture. As a result, spiritual nourishment tends to be emphasized, as opposed to seeking proper medical facilitation and this makes pastors not only susceptible to depression but also unwilling to treat it using the appropriate measures available. This is not enhanced by the fact that depression is seen as a sign of weakness rather than an opportunity to seek for help.

Pastor's lifestyles and their careers are inseparable, and such an overlap leaves no room for a distinction between personal and ministerial service obligations. This interlocking of obligations leads to a particular perception of them, which can be burdensome.

Claude Mariottini, who has worked as a pastor for a number of years, discusses on his blog that a number of suicides among pastors are brought about by depression and their lifestyles.[107] His input offers great insight since he has personally dealt with a few cases of suicide within his own church in Chicago and correlates each case with bouts of depression. In one instance, the pastor of a church in Georgia opts to take his own life because he could not feel God in his life.[108]

Kelly Givens observes a high trend in "pastoral suicide." Suicide in church members often comes about as a result of the failure to make decisions that not only tarnish the name of the pastor involved but also put their career in jeopardy.[109] Givens highlights an incident

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[107]Claude Mariottini, "When Pastors Kill Themselves" Claudemariottini.com. Accessed June 12, 2015.

[108] Ibid.

[109]Kelly, Givens, 2013, "Why are so many pastors committing suicide?" Crosswalk.com. Accessed June 12, 2015.

in which the spiritual advisor to President Barack Obama, also a father of three and founder of a megachurch, commits suicide following his admission to an affair with a fellow church member. In this instance, the pastor had already been pushed to the limit because of his inability to address an issue that may have led to the questioning of his moral stance.

Givens cites the Schaffer Institute which provides figures that, as a result of their lifestyles, about seventy percent of pastors have depression. Of this number, seventy-two percent admitted to being burnt out and seventy-one percent study the Bible only when they are about to give a sermon, which demonstrates that spiritual nourishment as prescribed by their position is not the best option and has actually not been a strong option for them. An overwhelming eighty percent of pastors believe that their work in the ministry has negatively impacted their personal and family lives, mostly because less than seventy-one percent of them have close friends with whom they feel they can trust enough to share sensitive issues. As a result, most pastors and religious leaders leave ministry services within five years.[110]

These statistics indicate some specific issues among the clergy. Many pastors feel a sense of isolation in their positions and the expectations that come with it. Choosing to be a pastor is in itself a difficult decision, and from that point in an individual's career, he or she is alone. Pastors often find themselves having to shoulder the burden of community members and congregations, so they have to constantly demonstrate strength and good resolve. Interestingly, most pastors have families and children and despite this fact, they seem not to have an outlet for their frustration.

There is an increased sense of isolation because it is also coupled with the distance some pastors feel from God, despite being engaged in His work. The ministry under which most pastors work for and the services required of them from the ministry tends to put a lot of

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[110]Kelly Givens, "Why are so many pastors committing suicide?" Crosswalk.com. Accessed June 12, 2015.

pressure on the ability of pastors to perform optimally and present the best of themselves to the congregation. As a result, the personal lives of pastors have no place in the public position they fill. Continuing with the article in *The Blaze*, Hallowell discusses one pastor whose plight is an example of such a situation. The pastor was unable to discuss his personal affliction with anxiety and depression when addressing his congregation, because he had a public image to maintain.[111]

Perhaps this is a reflection of how, during preparation, pastors are pressured to bring out the best in sermons. They need to be confident and self-assured when delivering sermons on counseling congregations because their words and actions are potent and carry a lot of weight in the community. It is perceived to be discouraging if pastors put themselves out in negative light by highlighting their own anxiety or depression. The pastor in Hallowell's story talks about his own embarrassment taking anti-depressants and the stigma that surrounds seeking such recourse for help or discussing such issues with members of the congregation.[112] Social pressure plays a central role in the psychological welfare of such religious leaders.[113]

As discussed earlier in this study, a number of pastors report to undergoing their depressive and spiritual journeys alone.[114] Some even purposely isolate themselves from family members and loved ones because of the shame attributed to such negative feelings. These feelings include anxiety, mood swings and persistent sadness, even hopelessness. The

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[111]Hallowell, "'The Darkest Time of my Entire Life': Preacher Reveals the Struggle that Nearly Led to his Death"

[112]Ibid.

[113]Ibid.

[114]David Robertson, *My Journey through Depression: a Pastor's Story*, (Strategic Publishing, 2011), 18.

constant necessity to exude confidence and positivity can become exhausting. Perhaps what needs to be done within churches is the reflection of humanity rather than divine aspiration that has negative consequences.[115]

Pastors also have very few moments of privacy due to the public nature of their service and the number of people who constantly want to seek advice from them. It tends to be beneath the notice of others that pastors are also human and may need moments to reflect on their own lives even while in service. The added pressure of constantly having to be available can make early stages of depressive behavior difficult to notice and early intervention is then not possible.[116]

Kenneth Moe notes that the spaces that pastors occupy are often a little unreal because of the way people perceive them as infallible, which is expected of them as men of God.[117] They are also put on a pedestal as family and community leaders; they are the shepherds of congregations as inscribed in the Bible. Worse still, Moe observes that in pastoral training, many would-be ministers are not adequately prepared for these aspects of the practice, which means that the entire system, both the community and training facilities, is failing pastors.[118]

Kenneth Moe points out that above fear of God, there is an apparent "fear of man," which some people tend to fear more than the truth. The public nature of ministerial practice makes it even more tempting for people in such positions to commit what would be perceived as sins.[119] Furthermore, it leads to more scrutiny and judgment, especially when facing

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[115]Ibid.

[16]Ibid.

[117] Kenneth Moe, *The Pastor's Survival Manual: 10 Perils in Parish Ministry and How to Handle Them* (Bethesda, 1995), 49.

[18]Ibid.

[119]Larson McCullough, *Psychotherapy with Mainline Protestants: Lutheran, Presbyterian, Episcopal/Anglican and Methodist*, Handbook of Psychotherapy and Religious Diversity, 2015.

decisions that any other person would make. There is the sense that being a pastor means that one must always make the right decisions.

The culture that surrounds pastors plays a central role to their lifestyles and personal choices. Tripp highlights that church practice attempts to emulate the idea of a heavenly kingdom because pastors are given power, mandate, control and reputation.[120] Their communities serves as their followers and the pressure that comes from such functions is overwhelming. Pastors can only consult God or the Bible and at times this ends up putting them further in a position of isolation and disconnect them from their congregations.[121]

However, this is not to say that practicing within the ministry or that performing pastoral duties is a negative pursuit. Pastors can still find healing in spiritual nourishment, which would not go against their lifestyles or the expectations of members of their families or the church. The Bible is able to afford nourishment and should not only be utilized when preparing for sermons or to advise others. Pastors can learn to use the information in it to address their own problems.[122]

The Bible is full of examples of people who had faced difficulty and chose not to take their lives. For instance, in the Book of Jonah, Chapter 4 verse 3, Jonah relents against the citizens of Nineveh to God saying "Lord, kill me instead, because I would rather die than live." Moses finds that he is "unable to bear this entire people alone" (Numbers 11:14-5) when he has to take the Israelites to the Promised Land.[123] Pastors can use these to mirror their own frustrations even when addressing their congregations.

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[120]Tripp, "The depressed pastor: the setup"

[121]Tripp, "The depressed pastor: the setup"

[122]Ibid.

[123]Num 11: 14-15 (NAB).

Tripp acknowledges that depression is at the heart of ministerial practice; however, the best way to deal with it is by accepting the status and seeking assistance.[124] He also urges spiritual nourishment by seeking the very thing that is the object of a pastor's functions: God.[125]

Research Question 3: Analysis and Response

Are pastors willing to admit to the fact that they are depressed?

The findings do agree with the null hypotheses premise that pastors are depressed because they fear stigma and retribution from clergy members as well as the public. In addition, pastors are not willing to admit that they are depressed because of their inability to assess whether they or other members of the clergy suffer from depression.

The findings do agree with the alternate hypotheses that pastors are willing and able to admit to depression because they have developed a better understanding of its causes. Furthermore, pastors are able to receive support from the clergy and pastoral community once they come forward with their admission. They also encourage other members of the pastoral community to openly discuss depression and find means of managing the problem.

On the whole, the study was aimed at understanding how the lifestyles of pastors make them susceptible to depression. Through opinion statements constructed around the lives of pastors, the study was able to gauge pastors' responses to the daily pressures of their vocation, while also gauging their conceptualization of depression and who they are likely to turn to when dealing with pressure related to depression. On the whole, it was established that a majority of pastors would turn to their religious faith as well as family members to counter pressure from their vocation and deal with conventional symptoms of depression.

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[124]Ibid.

[125]Ibid.

For instance, out of the forty respondents, fifteen found that talking to family members enabled them to cope with stress from ministry work. Almost half of the respondents did not believe that their lifestyle as pastors was a cause of strain to their family obligations. These strong family values may have to do with the predominantly married and previously married number of respondents. Having established familial backgrounds, it is only natural that these pastors seek comfort from family members. At the same time, respondents were able to admit that their ministry work gets in the way of their ability to spend time with their family members based on the report from family members that ministry work got in the way of private time.

Though pastors were willing to open up about their family situations, very few admitted to receiving counseling, either from the church or from private practitioners. These responses may be the real situations; however, they also serve to highlight the inability to open up on issues pertaining to depression. Some of the respondents admitted to feeling burnout, which is a sign of the onset of depression, still an overwhelmingly twenty-six out of forty respondents had never considered taking a leave of absence in context with their inability to serve members of their congregation. A significantly small number had never considered taking a sabbatical, which is highly recommended in ministerial service.

One interesting contrast in responses is the willingness to open up about family yet the unwillingness to make a compromise in their vocation. While many pastors, about thirty percent of respondents, admitted to experiencing burnout within five years of performing ministerial duties, an overwhelming sixty-five percent would not take a leave of absence. There is a strong level of commitment to the church coupled with the feeling that religious institutions are the key to countering symptoms of depression such as stress or burnout from work expectations. In fact, many pastors are inclined to seeing a spiritual counselor rather than a mental health practitioner because of their conceptualization of depression as a spiritual crisis rather than as a mental health crisis.

Another observation is that despite the glaring symptoms of depression that respondents identified with, even in small percentages, pastors were adamant that what they experienced was not related to depression. One question that arises is "Is the lack of admission of depression merely a case of denial or whether this is a coping mechanism"? It may also function as both, since stress, anguish and burnout are general experiences people have when strained from physical or emotional work. At the same time, pastors are able to find ways to counter these symptoms by reading the Bible (thirty percent) or talking to members of their family (thirty-seven percent).

The survey was designed to establish whether the hypotheses and research questions formulated could be validated from the participants' responses. Each of the research questions was also used to find an aspect of depression as understood by pastors through their responses to the survey. Responses to the first research question established that pastors are able to identify the causes of depression, although they do not necessarily associate it with the condition. At the same time, they are able to correlate symptoms with aspects in their personal and professional lives. In various instances throughout the survey, pastors made indirect links to their lifestyles with depression and there was some hesitation to closely identifying these variables with depression.

Research Question 4: Analysis and Response

Are pastors willing to seek professional assistance when dealing with depression?

The findings support the null hypothesis that education, training, years of pastoral ministry and the size of the clergy has little influence over the decision of pastors to choose professional assistance to deal with depression. In fact, their spirituality keeps them from seeking professional assistance as they believe it goes against biblical teachings and the principles of the pastoral community.

The findings do not support the idea of the alternative hypothesis that education, training and years of pastoral ministry have a positive influence on the choice to seek

professional assistance for suicidal depression. These variables increase exposure to mental health issues, giving pastors a greater understanding of the need to seek assistance from people with the ability to help them deal with depression appropriately.

The findings do agree with the secondary null hypothesis that attitudes towards mental health issues coupled with the perception of professional guidance counselors have an impact on the pastoral community's use of professional assistance. Because of medical professionals' non-affiliation to the church, pastors are unlikely to seek help from them.

The findings do not support the secondary alternative hypothesis that there is increasing evidence of pastors seeking assistance from professional guidance counselors who are affiliated with their beliefs. It reduces conflict that pastors may feel relating to the principles of the pastoral community and increases their confidence in the ability of professional assistance to address their issues appropriately.

Hart[126] advises pastors to seek support from their spouses and professional counselors when going through this mental illness. In most cases, pastors discover that they are depressed after a spouse points out certain symptoms. It is important to take these concerns seriously and seek professional help from a doctor or psychiatrist. Physicians will prescribe certain drugs to help ease some of the symptoms, while psychiatrists will seek to discover the root cause of the depression and formulate a comprehensive treatment plan.

Most of the other research questions had to accommodate a variety of answers and hypotheses because of the diversity of opinions. The final research question which poses whether pastors are willing to seek professional assistance when dealing with depression has

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[126]Archibald Hart, "Depressed, Stressed, and Burned Out**:** What's going on in My Life?" *Enrichment Journal* 23 (2015): 10

four different hypotheses that represent possible responses the researcher expected from the participants. Although some are null, they are valid for consideration. The researcher found that very few respondents were willing to seek professional assistance, even where such services were offered by the church as was the case in Grace City Baptist Church.

The results and findings have been affected by a variety of factors including the backgrounds of the pastors, their education, marital status and work experience. Direct correlations between demographics and survey responses cannot be made; however, they are sufficient to provide an overall evaluation of how one affects the other. As noted several times, the homogenous characteristics of the participants led to similar responses; nevertheless, the study allows for the inclusion of various nuances. Aside from providing input in research, these findings have implications for both the pastoral community and the mental health community, which will be explored in the following sections.

Options for Dealing with Depression

It is possible to find means to deal with depression through spirituality by turning to professionals who adhere to the Christian faith. Such a method does not compromise pastors' faith or their dealings with the ministry. If anything, they provide them with a positive outlet for their anxiety. Nevertheless, it has to be incorporated with relatively secular methods of treatment, such as seeking assistance from a mental health practitioner, and being open and honest about the issue and taking medication. This way, pastors have a good balance of treatment and can cope well with depression and anxiety.

Three case studies of how pastors have positively dealt with depression are important to highlight in this section. Two offer first-hand accounts of their experience while the other was narrated to a Huffington Post journalist. The three pastors have been deeply engaged in ministerial service and provide a lot of insight to the argument. They convey the different ways each pastor has chosen to deal with depression, by balancing both spiritual elements and the medicinal.

Meredith Melnick's article in the Huffington Post highlights the story of senior pastor Reverend Emily Freeman Penfield.[127] Reverend Penfield has served in the United Church in Alabama up to senior rank level. Her work has been intensive. She handles a number of cases of anxiety and depression among her congregation, even though she suffered depression herself. Reverend Penfield's choice to open up is one of the positive steps that members of the clergy need to take in order to address issues surrounding depression and to help alleviate the stigma around the topic. One of the first things Penfield was advised to do when she started feeling depressed was to pray and manage her breath. Penfield admits to using medication such as Xanax to enable her to cope and keep calm. She notes that no one in her church or seminary had introduced her to the term "clinical depression," nevertheless, she was able to gain support from this community in their own limited capacity.

An important issue that Freeman's testament raises is the importance of having a religious community that is accepting towards the predicament of pastors facing depression. In the Enrichment Journal,[128] Wayde I. Goodall and E. Glenn Wagner also reflect on the importance of coming out as the initial positive step towards dealing with depression. They begin by noting that anxiety and depression are the foremost occupational hazards for people working within the ministry and how this can greatly affect the performance of pastors and clergy members. The writers of the article describe their first-hand experience with depression and burnout and how "opening up" has been the most positive step they have taken to recovery and remission.

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[127]Meredith Melnick, "A Pastor Uses Her Own Experience to Counsel Depressed Parishioners." The *Huffington Post*, August 29, 2014, accessed June 29, 2015.

[128]Wayde I. Goodall & Glenn Wagner, "Coming out of the Dark: Two Pastors' Journey out of Depression" *The Enrichment Journal*, 2015.

From these two stories it can be observed that as soon as pastors are encouraged to speak out about depression, they are in a good position to seek help, first from their immediate community, then professionals, therapists and medical practitioners. Reverend Penfield, for instance, was able to seek professional help shortly after admitting her problem to her family members.[129] Jonathan Merritt, in conversation with megachurch pastor, Perry Noble, observed that depression breeds within isolation.[130] He echoed sentiments that it is necessary not just to speak out to members of the community but also to seek help through the appropriate channel, counseling.[131]

With increasing diversity in the field of counseling, pastors can comfortably consult with Christian psychologists and therapists. Goodall, for instance, found that seeking help from a professional who was affiliated to his religion not only gave his treatment better perspective, it also meant that he was not compromising any of his personal and Christian values in the course of treatment.[132] The Christian psychologist was able to prescribe medication that would not become addictive or intoxicating. Wagner[133] stressed that it is important to choose a Christian medical practitioner because of their holistic understanding of the convergence between religious aspects of treatment and the application of clinical methods.

The common thread within the cases is that there has been a positive change in attitude towards medication for depression. Both Goodall and Wagner admitted to taking

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[129]Melnick, "A Pastor Uses Her Own Experience to Counsel Depressed Parishioners."

[130]Jonathan Merritt, "Megachurch Pastor Perry Noble Admits to Depression, Suicidal Thoughts" *Religion News Service* February, 27, 2014 accessed June 29, 201.

[131]Ibid.

[132]Goodall & Wagner, "Coming out of the Dark."

[133]Ibid.

anti-depressants. Merritt noted that megachurch pastors are advocating for Christians struggling with depression and anxiety to consider taking mood-altering drugs that can help them cope.[134] He recommends sedatives and mild stimulants that have caffeine and that users should ensure they are medically endorsed.[135] Although mood-altering drugs work like intoxicants, church leaders assure their congregation and worshippers alike that taking antidepressants does not mean that one is subverting the teachings of the church. Emotional difficulties such as depression are brought about by dysfunctional thoughts and chemical imbalances. Chemical imbalance, until more recently, was more difficult to accept among clergy members until medication came to be embraced.

Goodall and Wagner, through their Christian psychologists, were able to identify non-addictive antidepressants that pastors can take, especially those with serotonin, so that their moods are well balanced without compromising their sobriety.[136] They argue that because serotonin is already naturally produced in the brain, there is no actual alteration taking place. The drug simply works to enhance the effectiveness of an already existing element in the body.[137] They compare such medication to insulin, and by doing so, they demonstrate that antidepressants are not harmful to the body, but have the effect of enhancing the necessary mechanisms of the body. When pastors feel comfortable in openly addressing depression and anxiety in their own lives, the church is a more fulfilling environment and pastors are then able to effectively cope with anxiety and depression.

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[134]Merritt, "Megachurch Pastor Perry Noble."

[135]Ibid.

[136]Goodall & Wagner, "Coming out of the Dark."

[137]Ibid.

Prayer and reading the Bible are still greatly encouraged by all the pastors in the case studies. Spiritual nourishment is still essential to treatment and in ensuring continuity when pastors return to practicing within their congregations. Tim Span certainly believes that Scripture can be used beneficially and ethically as a resource for counseling evangelists who are suffering from depression.[138] The operative word in this case is ethical, because of the conflicting ethical standards of the medical and religious fields. Religion can sometimes keep one from seeking help from science. Nevertheless, Span argues that evangelists are more comfortable seeking authority and comfort from the Bible, which is their primary text. In Timothy Chapter 2 verses16 and 17, the text posits that there is self-attestation of Scripture because of its reliability and "usefulness."[139] However, Span warns, Scripture must be used responsibly.[140]

Scripture has become part of post-modern solution seeking therapies. As mentioned before, depression is perceived as an emotional imbalance. Within the Bible, Span notes that there are references that can enable thought stopping, thought shaping and cognitive disputation.[141] When dealing with pastors who are depressed, the Bible can be used to address such cognitive distortions as perfectionism, magnification, discounting the positive and mind reading.[142] In a website entry, Southern View Chapel highlights different physical and emotional symptoms of depression with reference to specific sections of the Bible.[143] For

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[138]Tim Span, "Using Scripture in Counseling Evangelicals," *Thesis and Dissertations* 950(2009), 86.

[139]Tim 2: 16-17 (NAB)

[140]Span, "Using Scripture in Counseling Evangelicals."

[141] Ibid.

[142]Span, "Using Scripture in Counseling Evangelicals."

[143] Southern View Chapel, "A Look at Depression through the Lens of Scripture," *Resources* last modified December 1997, accessed August 12, 2015.

instance, in Psalms, Chapter 32, pessimism is highlighted; in I Kings, Chapter 19, thoughts of suicide; in Psalms, Chapter 2; sleeplessness and in a variety of other chapters in the Psalms are feelings of apathy, withdrawal, blame, guilt and physical problems such as headaches and backaches.[144] Such correlations are extremely important because they reinforce and even lend authority to scientific views of depression.[145]

When using Scripture for therapeutic purposes, both the therapist and patient are seeking "grace events" that provide narratives on how God is already at work in the life of the client and is already providing him with the solutions of how to deal with depression.[146] Such grace events include seeking Christ as highlighted in Romans Chapter 5, verses 1-11; reprogramming thinking in James Chapter 1; reaching out to others in Philippians Chapter 2 among other sections of the Bible. From this examination, this paper posits that religion should not be at the fringe of intervention, it should also be central.[147] When pastors seek assistance from secular therapists and psychologists, they are often afraid to discuss their own religious inclinations, making therapy ineffective. However, in an environment where the therapist is inclined towards faith, pastors are likely to open up because they are in a safe environment, and a safe environment is important for therapy.[148] Using the Bible responsibly as Span urges, means not merely reading Scripture, but actively engaging with it in daily outlook.[149]

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[144]Southern View Chapel, "A Look at Depression through the Lens of Scripture."

[145]Ibid.

[146]Span, "Using Scripture in Counseling Evangelicals."

[147]Ibid.

[148]Ibid.

[149]Span, "Using Scripture in Counseling Evangelicals."

Depression creeps up slowly, meaning that pastors must strive to take preventative steps at an early stage. This implies implementing coping techniques as soon as one starts to experiences burnout. According to Hart[150], pastors must learn to take direct action by actively trying to identify the sources of the problems in their lives, confronting them, and formulating positive solutions. Ignoring the root of the problems just aggravates the situation and increases the risk of getting depression. At times, pastors may need to take indirect action whereby they discuss the problem, adapt to its source and divert their attention from it by indulging in other activities.

From the findings compiled from this study, there are implications that the pastoral community as well as the mental health professionals should take heed to meeting the mental health needs of pastors.

Implications for the Pastoral Community

One of the central themes in this study is the focus on the pastoral community. By carrying out a case study of Grace City Baptist Church, the researcher was able to incubate the space, while producing a microcosmic perspective of the perception of depression among pastors and how their lifestyles lead to symptoms of depression such as burnout and stress from ministerial service. For this reason, the pastoral community needs to implement some of the study's suggestions, while also developing a better understanding of depression on a clinical level.

One of the implications this research has on the pastoral community is in enabling the institution to establish mechanisms of intervention that are interconnect with their religious practices and at the same time prevent instances of medical neglect. As noted, the C.A.R.E and Seminary models have components of self-help for pastors, while also providing

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Archibald Hart, "Depressed, Stressed, and Burned Out**:** What's going on in My Life?" *Enrichment Journal* 23 (2015): 10

channels though which pastors can seek support and intervention without compromising their religious values. The pastoral community has been urged to establish a network of clinical practitioners whose practice does not cause conflict with church teachings and expectations and at the same time does violate the principles of medical ethics.

Implications for Mental Health Professionals

The study adds to literature on the referral of pastors to mental health professionals, the application of suitable measures of intervention and an understanding of the susceptibility of pastors to depression as a result of their lifestyles. At the same time, the study highlights the need to create competent methods of intervention for dealing with pastors suffering from depression through the C.A.R.E. and seminary models. The researcher's study identifies how progress can be made from prior conceptualizations of depression to a more current and clinically aware understanding of its causes and treatment. One element the study reveals is the perception of pastors on depression.

The study reveals that it is important for mental health professionals to recognize the role of pastors as more than gatekeeping. Mental health professionals should follow ethical and legal protocols when dealing with pastors and should be culturally competent in order to offer suitable treatment and management to pastors who approach them. They should understand the specific needs of their clients and the sensitive issues surrounding discussion on depression in the church. When a church is the referral source, mental health practitioners should ensure they are equipped to meet both the clinical and personal needs of pastors suffering from depression.

The study has been specifically careful to underscore the perception that pastors with minimal training in counseling are capable of understanding clinical aspects of depression. Previously, studies have been more concerned with pastoral counseling as a component that operates outside conventional treatment from mental health professionals. However, mental health professions are not only clinically competent, they are growing to be conscious of the

different clinical contexts where they can offer services, including under church auspices. Hence, the study encourages increased interaction between pastors and clinicians to produce positive health outcomes for worshippers suffering from depression. The interface between pastors and medical professionals will be helpful in changing perceptions on seeking professional assistance for depression.

Benefits of the Models

One of the evident benefits of the models is that it enhances church involvement for pastors. The models are used to equip pastors and their ministries with resources on how to cope with depression that considers Scripture and clinical requirements. Seminary education is beneficial to preparing pastors for their period in servitude including administration, teaching, leading and how to develop coping mechanisms when work pressure increases. Pastoral care should be a core element of seminaries and ministries should determine the best way to offer this mode of instruction. A survey should be constructed to determine how pastors perceive seminary training and to measure their perception of pastoral care offered in the seminary.

Paying attention to pastoral care in the church is biblical and essential to getting healthy responses from pastors. Historically, this model is impinged on the idea that healthy pastors also make a congregation healthy and has a positive impact on the pastoral community. The goals of these models are (a) to equip pastors with ways of dealing with and addressing depression, (b) to understand the degree of pastoral care offered by various churches and how this can be implemented and improved, (c) to determine the areas pastors are most likely to need care ad management, and (d) to research programs and solutions available for churches to implement. It is hoped that these models will be developed in the future and are characterized by the following elements:

1. Continued application of Biblical principles
2. Sharing of personal experiences so that more pastors can open up and more discussions around depression and anxiety can be spurred by the church
3. Spiritual growth by facilitating safe spaces where pastors can discuss and reflect
4. Leadership to ensure pastoral care is constantly provided to those in need and who will facilitate opportunities for pastors to seek assistance
5. Institute effective evangelic friendships so that pastors have institutional support from peers

To be able to build on the model, seminars would have to include diverse perspectives and find ways of working together with people from clinical backgrounds. Furthermore, close attention would have to be given to Scripture to determine how best to construct spiritual models of support for pastors. Some of the principles of prayer and discipleship would be included, specific to ideas of forging closer bonds between members of the church, in order to enhance leadership and counsel. The church should be in a position to institute a holistic Seminary and C.A.R.E. model to cater to pastors and build on their personal experiences.

Recommendations for Future Research

The participants who provided information for this study were homogenous, which translated to limited variability in results and responses to the research questions in a way that "pushes back" into the misconceptions that already exist in the perceptions of depression within the clergy. It is hoped that the scope of this study may be expanded in order to present an expanded perspective and perhaps new input on a topic that has been much discussed in the literature. Future studies would do justice to the topic by conducting research in a manner that represents demographic variability and perhaps by gaining perspective from people from different religious denominations.

This study has established the need to encourage training opportunities for pastors in order for them to better understand depression, especially on a clinical level. While most of the participants have attained some level of higher education and have had some minimal training in counseling, it is surprising the level of prejudice that exists against clinical methods of countering depression and the dated perceptions of the reasons for depression. Perhaps a focus on hypothetical scenarios would have enabled congregations to relate information they have on depression with real assessments in a manner that encourages clear and rational thought on the topic, rather than responses solely guided by religious inclinations.

At the level of research design, the study benefited from a mixed-method approach where qualitative information in the form of an analysis of opinion statement was correlated against the frequency of responses. The data collection method and analysis provided comprehensive information on perceptions of respondents. Nevertheless, it may have been beneficial to conduct semi-structured interviews to gain information that was personalized and added depth to the topic. Such interviews would also have contextualized the rationale behind the responses to the survey as well as context on how the demographic background of respondents may have influenced responses.

A more ambitious study would examine comparative perceptions of depression by drawing from responses of pastors and from members attending a particular community church. Such a study would attempt to examine whether the perceptions of pastors differ from members' perceptions who attend the church, especially with relation to clinical views on depression and the types of treatment and management each respondent would choose. It would also be interesting to gain responses on opinion statements from church attendees. For instance, "Are they more likely to seek professional assistance"? Do they believe pastors should be given the option of seeking conventional treatment for depression in light of their religious principles?

Limitations

The sample size of the study was smaller than anticipated and desired to cover the scope, depth and breadth of accompanying research. This may have to do with the size of the church and the general perceptions in the pastoral community on depression and related topics. Furthermore, providing potential participants with a glimpse of the questionnaire may have discouraged participation, although this provision was with the best of intentions. Viewing the questionnaire may have given potential participants time to reflect on what they perceived to be the most appropriate responses, however, which may not have reflected their responses.

The study method is largely quantitative as it relies on frequencies and percentages to answer research questions and prove or nullify hypotheses that would otherwise admit to more nuances. The survey questionnaire also guided responses, therefore, pastors were unable to fully explore their own responses and may have been inclined towards a particular choice because it would have been easier. However, a qualitative or mixed-methods study would have taken a lengthy period of time to carry out and thematically analyze. The study would have gained more information from semi-structured in-depth interviews, although there would have been fewer respondents willing to participate in such a study design.

Initially, this study was conceptualized to examine the causes of depression among pastors and included an examination of how their lifestyles were likely to cause depression and offer various real-life examples and case studies of depression among pastors that led to suicide. However, the paper began to focus on the perceptions of pastors with relation to their understanding of depression, how to seek assistance for depression and how churches can come up with holistic models such as the C.A.R.E. and Seminary models to help church members deal with symptoms of and manage the onset of depression. This expanded the scope of the study, while also making it more focused on management principles.

Although the C.A.R.E. and Seminary model were identified as suitable interventions for depression, one of the greatest limitations to assisting pastors with depression is their hesitation in seeking professional help. At the same time, although professionals may be called upon, they must have affiliations with the relevant church, which may lead to bias in their mode of treatment and management and may also limit the scope of intervention measures they can apply to pastors. With a better conceptualization of depression, perhaps churches will be open to pastors seeking assistance, even from mental health professionals who are not necessarily affiliated with the church.

Another issue that arose when carrying out research on suitable models is the limited scholarly, medical and spiritual literature on the C.A.R.E. model, as well as guides on how to come up with a comprehensive seminary model. There are also very few studies that examine the effectiveness of these models and whether they are instrumental in enabling pastors to find ways to counter depression. These studies also did not address responsiveness from pastors. Primary research on the C.A.R.E. and Seminary models was also very limited, therefore, the study relied on being able to balance scholarly, medical and spiritual views on each model to incorporate in the study.

Study Summary

Depression generally interferes with daily functioning and the relationships individuals have with one another. It has a fairly high prevalence within the pastoral community. Depression is a common occurrence within society, however, it is still shrouded in stigma especially in more conservative communities and backgrounds, which leads to adverse effects and responses. The frequency may be much higher because information on this subject is limited as few members of the church are willing to openly discuss personal experiences with depression and to respond to surveys as demonstrated in this study. At the same time, religious practices are conservative, thus religious leaders are unwilling to utilize conventional methods to counter depression.

The study has been able to highlight how pastors perceive depression and identify factors related to depression including stress and burnout. The study was incubated within the Grace City Baptist Church where at least forty pastors were able to offer responses to the researcher's survey on their perceptions of depression and how their lifestyle as pastors makes them susceptible to depression. Through quantitative analysis of survey results, the researcher has been able to correlate research questions, hypotheses and literature with responses from participants. Additionally, the researcher has been able to gain a glimpse of the participants' environment and background and how those elements influenced their responses.

It is hoped that the findings and models offered in this study will be beneficial to the pastoral community and to the medical health community in order to identify the best ways of educating pastors on depression. Furthermore, the researcher believes that the models will offer viable alternatives for addressing mental health issues.

Finally, the causes of depression appear to be unlimited according to the researchers study. The causes identified most often are loneliness or isolation, lack of religious belief, excessive drug or alcohol use and demonic influence. To adequately deal with depression, no one answer is available, but a multi-approach must be considered. The research literature and the empirical findings propose that a thorough look at the role of spirituality, consultation with psychologists and therapists, medication, and the application of preventive models in combination, will provide a ray of hope for a solution. The foundation for pursuing a solution may call for the churches to change their structures and attitudes by addressing the problem of depression in a practical and proactive manner.

As a result of the literature review, surveys, statistical and data analyses, there are available coping mechanisms. Still, there is no conclusive agreement on how to best address the needs of pastors suffering from depression and/or other forms of mental illness. This field of study is open for future exploration.

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APPENDIX A

The Liberty University Institutional Review Board has approved this document for use from 5/13/15 to 5/12/16 Protocol # 2174.051315

CONSENT FORM

An Analysis of Causes and Impacts of Depression in Pastors

DeRienzia Johnson
Liberty University
Liberty Baptist Theological Seminary

You are invited to participate in a research study of *An Analysis of Causes and Impacts of Depression in Pastors*. You were selected as a possible participant because you indicated that you are a pastor who has suffered from depression. I ask that you read this form and ask any questions you may have before agreeing to be in the study.

DeRienzia Johnson, a doctoral candidate in the Liberty Baptist Theological Seminary at Liberty University, is conducting this study.

Background Information:

The purpose of this study is to help pastors understand that there are positive options to relieving depression.

Procedures:

If you agree to participate in this study, I would ask you to do the following things: (1) Participate in an individual interview of approximately one to two hours with the researcher. (2) Verbally respond to a set of pre-determined interview questions. (3) Respond freely and truthfully as the information will be completely confidential. (4) Complete a written journal giving personal detail of experience with depression or suicidal thoughts within two months after the interview and share with the researcher.

Risk:

The only anticipated risk is that the participants might relive the experiences through sharing their stories. Discussing their periods of depression might cause some temporary sadness or discomfort for some participants. Mandatory reporting is required for incidents of child abuse, child neglect, elder abuse or intent to harm self or others conveyed to the researcher during the interview process. If you experience depression please visit http:aacc.net/ where you will find counseling resources.

Benefits:

Participants will not receive a direct benefit, but they will be able to share their experiences in a non-threatening, confidential manner. Sharing their experiences may be therapeutic and relieving for the participants. Past research has shown that talking about depression is usuallly the first step towards healing. Each participant will be given access to the final research dissertation which could be beneficial in helping them to cope with depression.

Compensation:

Participants will not receive compensation for their participation in the research project.

Confidentiality:

The records of this study will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify a participant. Research records will be stored securely and only the researcher will have access to the records.

APPENDIX B

IRB Approval Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

May 13, 2015

DeRienzia Johnson
IRB Approval 2174.051315: An Analysis of Causes and Impacts of Depression in Pastors

Dear DeRienzia,

We are pleased to inform you that your above study has been approved by the Liberty IRB. This approval is extended to you for one year from the date provided above with your protocol number. If data collection proceeds past one year, or if you make changes in the methodology as it pertains to human subjects, you must submit an appropriate update form to the IRB. The forms for these cases were attached to your approval email.

Thank you for your cooperation with the IRB, and we wish you well with your research project.

Sincerely,

Fernando Garzon, Psy.D.
Professor, IRB Chair
Counseling

(434) 592-4054

LIBERTY
UNIVERSITY.

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APPENDIX C

Interview Guide

1. Who are you most likely to turn to when you have a family or personal conflict or issue?
    a) Fellow congregations
    b) The Bible
    c) A senior clergyman
    d) Friends and family

2. Does your mate see your work schedule and pastoral role as a source of conflict and complain of insufficient quality time?
    a) Often
    b) Sometimes
    c) Not at all

3. Have you felt burned out within the first five years of your ministry?
    a) Often
    b) Sometimes
    c) You can't tell

4. Have you needed to take a leave of absence from your ministry because you felt unable to meet the needs of your congregation?

    a) Yes
    b) No
    c) I have never considered it

5. Have you ever felt that pastoral ministry is hazardous to your family's well-being and health?

    a) Yes
    b) No
    c) I have never considered it

6. Does Grace City Baptist Church provide spiritual counselors or counseling to pastors?

    a) Yes
    b) No
    c) Not that you're aware of

APPENDIX C

Interview Guide (continued)

7. How often have you gone to see a spiritual counselor?
   a) Once
   b) Sometimes
   c) Never

8. Would you leave the pastorate because of your depression if you had somewhere else to go or some other vocation you could do?
   a) Yes
   b) No
   c) Have never considered it
   .
9. How often have you experienced severe stress causing anguish, worry, bewilderment, anger, depression, fear, and alienation?
   a) Often
   b) Sometimes
   c) Never

10. What enables you to cope best with the stress of ministry work?
    a) Reading the Bible
    b) Talking to fellow congregations
    c) Reflecting
    d) Talking about it with members of your family

11. Do you feel under pressure to have a perfect family and character?
    a) Sometimes
    b) Never
    c) Not often

12. What would keep you from committing suicide?
    a) Fear of condemnation
    b) Perception from peers and congregations
    c) Religious belief

APPENDIX D

Table 3.3.1

Attitudes toward mental health

Opinion statement	**Frequency**	**Percentage**
When you get right down to it, depressed worshippers should not be a clergyman's responsibility. Therefore, they should be referred to mental health practitioners.		
Strongly Agree	8	20
Partly Agree	6	15
Not Sure	4	10
Partly Disagree	12	30
Strongly Disagree	10	25
Mental health practitioners are too evasive when it comes to facing a problem.		
Strongly Agree	18	45
Partly Agree	7	17.5
Not Sure	11	27.5
Partly Disagree	3	7.5
Strongly Disagree	1	2.5
I feel the work of a mental health practitioner conflicts with the work of a pastor.		
Strongly Agree	15	37.5
Partly Agree	15	37.5
Not Sure	3	7.5
Partly Disagree	7	17.5

Strongly Disagree	0	0
I feel the majority of emotional disturbances should be handled by the clergyman.		
Strongly Agree	27	67.5
Partly Agree	9	22.5
Not Sure	1	2.5
Partly Disagree	3	7.5
Strongly Disagree	0	0
On the whole, mental health practitioners are very competent.		
Strongly Agree	32	80
Partly Agree	6	15
Not Sure	0	0
Partly Disagree	2	5
Strongly Disagree	0	0
Psychiatric treatment takes too much time and gets too poor results.		
Strongly Agree	12	30
Partly Agree	14	35
Not Sure	4	10
Partly Disagree	7	17.5
Strongly Agree	3	7.5

The mental health practitioner's attitude toward the patient and his problem is for the most part a positive one.		
Strongly Agree	2	5
Partly Agree	5	12.5
Not Sure	4	10
Partly Disagree	7	17.5
Strongly Disagree	21	52.5
In my opinion there are more "odd-balls" in psychiatry than any other profession.		
Strongly Agree	29	72.5
Partly Agree	7	17.5
Not Sure	4	10
Partly Disagree	0	0
Strongly Disagree	0	0
I feel that mental health practitioners overemphasize the sexual aspects of life as a cause of mental disorders.		
Strongly Agree	25	62.5
Partly Agree	9	22.5
Not Sure	1	2.5
Partly Disagree	4	10
Strongly Disagree	1	2.5
I have been greatly impressed by the results of psychiatric treatment		
Strongly Agree	2	5
Partly Agree	4	10

Not Sure	5	12.5
Partly Disagree	2	5
Strongly Disagree	27	67.5

Appendix E

Table 3.3.2

Causes of Depression

Opinion statement	**Frequency**	**Percentage**
Loneliness or isolation is a cause of depression.		
Strongly Agree	24	60
Partly Agree	10	25
Not Sure	1	2.5
Partly Disagree	4	10
Strongly Disagree	1	2.5
Family and/or domestic disputes are causes of depression.		
Strongly Agree	0	0
Partly Agree	4	10
Not Sure	0	0
Partly Disagree	2	5
Strongly Disagree	34	85
Demonic influence is a cause of depression.		
Strongly Agree	23	57.5
Partly Agree	10	25
Not Sure	3	7.5
Partly Disagree	3	7.5
Strongly Disagree	1	2.5
Lack of religious belief is a cause of depression		
Strongly Agree	32	80
Partly Agree	8	20

Not Sure	0	0
Partly Disagree	0	0
Strongly Disagree	0	0
Insufficient will power, lack of self-control, is a cause of depression.		
Strongly Agree	19	47.5
Partly Agree	11	27.5
Not Sure	2	5
Partly Disagree	5	12.5
Strongly Disagree	3	7.5
Trouble adjusting on the job is a cause of depression.		
Strongly Agree	10	25
Partly Agree	15	37.5
Not Sure	0	0
Partly Disagree	12	30
Strongly Disagree	3	7.5
Stress is a cause of depression.		
Strongly Agree	19	47.5
Partly Agree	11	27.5
Not Sure	0	0
Partly Disagree	10	25
Strongly Disagree	0	0

Excessive drug or alcohol use causes depression.		
Strongly Agree	26	65
Partly Agree	9	22.5
Not Sure	1	2.5
Partly Disagree	2	5
Strongly Disagree	2	5
Self-pleasure and/or sexual habits are causes of depression.		
Strongly Agree	26	65
Partly Agree	12	30
Not Sure	1	2.5
Partly Disagree	1	2.5
Strongly Disagree	0	0
Depression is inherited.		
Strongly Agree	19	47.5
Partly Agree	17	42.5
Not Sure	1	2.5
Partly Disagree	1	2.5
Strongly Disagree	2	5
A run-down physical condition is a cause of depression.		
Strongly Agree	20	50
Partly Agree	7	17.5
Not Sure	0	0
Partly Disagree	10	25
Strongly Disagree	3	7.5

Appendix

Table 3.3.3

Perceived Self-Competency

Opinion statement	**Frequency**	**Percentage**
I feel quite comfortable in caring for depressed congregations.		
Strongly Agree	10	25
Partly Agree	12	30
Not Sure	5	12.5
Partly Disagree	7	17.5
Strongly Disagree	6	15
I feel pretty competent and comfortable in talking with congregations about their personal problems.		
Strongly Agree	15	37.5
Partly Agree	12	30
Not Sure	6	15
Partly Disagree	2	5
Strongly Disagree	5	12.5
My training and experience are such that I feel competent to take on most cases of depression among my congregations.		
Strongly Agree	17	42.5
Partly Agree	10	25
Not Sure	4	10
Partly Disagree	4	10
Strongly Disagree	5	12.5

I do not know what to do for many of my depressed congregations.		
Strongly Agree	7	17.5
Partly Agree	5	12.5
Not Sure	2	5
Partly Disagree	15	37.5
Strongly Disagree	12	30
I do not have the background to help depressed congregations.		
Strongly Agree	3	7.5
Partly Agree	7	17.5
Not Sure	3	7.5
Partly Disagree	13	32.5
Strongly Disagree	14	35
My training and experience in handling depressed congregations are adequate.		
Strongly Agree	15	37.5
Partly Agree	12	30
Not Sure	3	7.5
Partly Disagree	10	25
Strongly Disagree	0	0
My background severely limits my having much success with depressed congregations.		
Strongly Agree	4	10
Partly Agree	2	5
Not Sure	1	2.5
Partly Disagree	16	40

Strongly Disagree	17	42.5
I have a good understanding of how to help depressed congregations.		
Strongly Agree	12	30
Partly Agree	15	37.5
Not Sure	2	5
Partly Disagree	6	15
Strongly Disagree	5	12.5
Most depressed congregations need more help than I can give.		
Strongly Agree	4	10
Partly Agree	8	20
Not Sure	2	5
Partly Disagree	14	35
Strongly Disagree	12	30

Appendix G

Table 3.3.4

Recognition of the Need for Help

Opinion statement	Frequency	Percentage
There is something admirable in the attitude of a person who is willing to cope with depression without resorting to professional help.		
Agree	17	42.5
Partly Agree	15	37.5
Partly Disagree	5	12.5
Strongly Disagree	3	7.5
I would want to get professional help if I were depressed for a long period of time.		
Agree	5	12.5
Partly Agree	7	17.5
Partly Disagree	8	20
Strongly Disagree	20	50
I might want to have professional counseling in the future.		
Agrees	12	30
Partly Agrees	4	10
Partly Disagrees	16	40
Strongly Disagrees	8	20
Considering the time and expense involved in professional help, it would have doubtful value for a person like me.		
Agrees	23	57.5
Partly Agrees	7	17.5

Partly Disagrees	5	12.5
Strongly Disagrees	5	12.5
A person should work out his or her own problems; getting professional help would be a last resort.		
Agrees	19	47.5
Partly Agrees	13	32.5
Partly Disagrees	3	7.5
Strongly Disagrees	5	12.5
Personal and emotional trouble, like many things, tends to work out by themselves.		
Agrees	21	52.5
Partly Agrees	12	30
Partly Disagrees	3	7.5
Strongly Disagrees	4	10

Appendix H

Table 3.3.5

Confidence in Mental Health Professionals

Opinion statement	Frequency	Percentage
If I believed I was depressed, my first inclination would be to get professional attention.		
Agrees	12	30
Partly Agrees	3	7.5
Partly Disagrees	20	50
Strongly Disagrees	5	12.5
The idea of treatment by a mental health professional strikes me as a poor way to get rid of emotional conflicts.		
Agrees	9	22.5
Partly Agrees	10	25
Partly Disagrees	12	30
Strongly Disagrees	9	22.5
If I were experiencing serious depression at this point in my life, I would be confident that I could find relief in professional help.		
Agrees	6	15
Partly Agrees	12	30
Partly Disagrees	17	42.5
Strongly Disagrees	5	12.5
A person with depression is not likely to get better alone; he or she is likely to get better with professional help.		
Agrees	17	42.5

Partly Agrees	12	30
Partly Disagrees	6	15
Strongly Disagrees	5	12.5