Spiritually Guided and Bridging the Gap: An Inquisitive Analysis on the Correlation of Pastoral Counseling and Mental Health

A Thesis Project Submitted to
the Faculty of the Rawlings School of Divinity
in Candidacy for the Degree of
Doctor of Ministry

Department of Christian Leadership and Church Ministries

by

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October 2020
Special Acknowledgements

I give thanks to my children for their unswerving support as I spent time away in the ministry. To my wonderful mother, Mildred Taylor, thanks for your words of encouragement, prayers and believing in me to accomplish another milestone in my life.

To my wonderful godson Andre Walters for encouraging me and being beside me every step of the way. Thank you when I needed a “behind the scenes” audience to listen to my thoughts regarding various aspects of my research.

Thanks to Pastor Louise Baylor, Dr. Shirley McCoy, and Dr. DG Baker, for your support and prayers.

*The Lord is my light and my salvation; whom shall, I fear?*
Abstract

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This research study evaluates the outcomes of pastoral counseling on mental health within a predominantly African American congregation in the southeastern United States. The research study is intended to build a further understanding of the pastor’s role in counseling individuals with mental health conditions, given individuals seek counseling as a treatment option. To evaluate those perceptions, the researcher analyzed data collected from a survey. The outcomes from this qualitative data study suggest that pastoral counseling alone is ineffective given several factors such as individual failure to seek counseling, no suggested mental-health related issues within the sampled population, and ethnicity barriers. Furthermore, the results of this study can bridge the gap between individuals, counselors, and pastors.
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Chapter 1

Despite the controversial relationship between religion, psychology, and psychiatry, individuals refer to spiritual practices to cope with stressful life events. There is an increasing awareness in the connection between spirituality and religion’s influence in mental health. Prior studies indicate that clients who seek pastoral counseling also address spirituality and religion in their therapeutic conversations; spirituality and religion are essential to many individuals in the United States.¹

The adverse effects that untreated mental health problems have on society and the economy can affect everyday life for individuals causing discomfort to the individual, family members, or caretakers. Psychological disorders such as severe depression affect the daily life of the individuals, family members, and it could also impact their friends. There are many treatment options readily available for individuals suffering from ailments, such as anxiety, depression, suicide, and substance abuse, which were recognized to be successful. “Typical therapy options include interpersonal psychotherapy, cognitive behavioral therapy, psychodynamic, and existential therapy.”² Among the global mental health issues, depression ranks the most common mental health issue in areas such as the U.K. It is the central focus of research that explores the connection between spirituality and mental health.³ Prior evidence examines the relationship


between populations, which demonstrates quantitative measures of the reduced level of anxiety in areas such as anxiety or stress when joined with spiritual techniques. ⁴

Research suggests that many pastoral counselors only address spiritual issues, while individuals believe pastoral counselors have little expertise with psychotherapeutic theories. ⁵ Preferably, highly religious clients aim towards counselors who firmly mirror the same religious values. Furthermore, increased levels of reported religiosity result in stronger reactions to spiritual mechanisms of counselor descriptions. Additional research is required to evaluate the perceptions of individuals, counselors, and the functions that pastoral counseling contributes to cohesively to psychotherapeutic counseling. ⁶ Research provides a contrast between pastoral and psychotherapeutic counseling; however, more clarification and investigative studies are essential to demonstrate the outcomes of pastoral counseling further.

The Church's role in caring for members of the community with acute mental illness is crucial as statistics prove that individuals with the diagnosis are continuing to rise. Recently, mental health clinicians and psychiatrists recognized the relevance of spirituality and religion as an integrated experience on the delivery of mental health services. ⁷ Religious beliefs and counseling affect mental health outcomes by utilizing combined coping mechanisms for individuals with acute mental illnesses. The collaborative efforts of the Church, such as the resources offered in religious communities' and the support to loved ones from family members

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in the Church, provide a robust treatment option for individuals by limiting barriers and aiding victims in many mental ailments such as substance abuse. While findings propose the possibility of effective collaboration between clinicians, churches, and health care organizations, barriers are formed.

Ministry Context

While a collaborative approach is necessary, are members of the Church and the community actively seeking support to mediate mental health issues? The support given to an individual from the clergy, pastor, or religious congregational members is widely considered a critical mediator between both spiritual and mental health. “Mental health affects a wide range of people from all demographics, but the race/culture component stands out as a strong clustering factor.” African Americans are also less likely to seek mental health counseling from professionals compared to any other majority ethnic group. According to the U.S. Department of Health and Human Services, only 15.7% of all African Americans diagnosed with a mood impairment seek counseling from a professional, and 12.6% of African Americans diagnosed with anxiety are seeking treatment. Barriers to seeking treatment are present in African Americans as they consist of social stigmas, the denial of symptoms, cultural norms, and social norms. Although African Americans are not proactively seeking professional counseling

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9 Ibid.
12 Ibid., 32.
13 Ibid.
14 Ibid.
by a licensed psychotherapist, research is revealing some evidence that they are reaching out to
church-based ministries for treatment for mental health issues.\textsuperscript{15} Spiritual researchers
approaching this topic are taking a holistic approach, evaluating the way individuals view their
spiritual worldview while exploring cognitive, emotional, interpersonal, emotional, and
behavioral components. The elements of religiosity are increasingly discussed in psychiatry as
studies show that religious individuals appear to improve coping skills and abilities with severe
mental disorders alongside reducing suicide attempts.\textsuperscript{16}

Problem Presented

The research performed will examine a representative sample of members from the
church known as Deliverance Center for All Nations to determine how many members
underwent or currently undergoing pastoral counseling as a treatment option of acute mental
illnesses and what their outcomes are. The results from this research are not directly beneficial to
the subjects but will offer awareness and expertise, bridging the knowledge gap. Statistical
analysis will support each hypothesis as stated:

\begin{itemize}
  \item[H_0:] There is a positive correlation between the subject mental health outcome and the
  pastoral counseling session received.
  \item[H_1:] There is no correlation between the subject’s mental health outcome and the pastoral
  counseling session received.
\end{itemize}

\textsuperscript{15} Jackson, “Licensed Professional Counselors’ Perceptions,” 86.

\textsuperscript{16} Simon Jones, Keith Sutton, and Anton Isaacs. "Concepts, Practices and Advantages of Spirituality
Among People with a Chronic Mental Illness in Melbourne." \textit{Journal of Religion and Health} 58, no. 1 (July 28,
Purpose Statement

The purpose of this quantitative descriptive research study on the relationship between pastoral counseling on mental health is to gain a better understanding of the relationship between pastoral counseling and mental health. The specific aims of this study are (1) to add to the prior findings of other researchers other than my current research in order to determine whether a sample population of individuals in the Church is seeking pastoral counseling as a treatment option; (2) determine within that population whether pastoral counseling has a positive outcome on individuals with acute mental ailments. Research helps to understand the integration of pastoral counseling and mental health, active practicing pastoral counselors, and whether pastors can serve as educators to mitigate care plans for individuals with acute mental illnesses. Recent data, prior to Covid-19, suggests there is an increasing number of individuals diagnosed with an acute mental illness.

Basic Assumptions

The subjects included in the study will answer the interview questions in a concise, honest manner, limiting bias. The researcher assumes that the subjects participating in the survey are Christian, limiting nonfaith-based world views that will present research bias. The inclusion criteria of the sample are substantial; therefore, assures all subjects have experienced a similar phenomenon of the study. Subjects have a sincere interest in participating in the research study and do not present ulterior motives, such as using this study to impress their pastor or gain benevolence offering.

Definitions

This section specifies adequate definitions for several referenced key terms

**Acute Mental Illness** is a significant and distressing symptom of a mental illness requiring intervention such as treatment. Acute mental illness can be a person's first experience, repeated episode, or worsening in symptoms. 18

**Anxiety Disorders** is formerly called neuroses; they are characterized by an excessive level of anxiety, developing in some patients to episodes of panic. 19

**Bipolar Disorder (Manic-Depressive Illness).** A mental state described by intense mood swings, depression alternating with manic behavior. 20

**Delusions.** These are false beliefs that are not grounded in reality. 21

**Depression** is a biological illness altering brain chemistry that can progress to a state of morbid and extreme sadness, despair, and hopelessness. 22

**Obsessive-Compulsive Disorder.** *OCD* Individuals with OCD are plagued continuously by fears or thoughts, "obsessions" that cause them to perform certain routines or rituals "compulsions." 23 *Post-traumatic stress disorder PTSD* is a condition that develops following a traumatic or terrifying event in which individuals affected and left having lasting or frightening

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19 Ibid.

20 Ibid.

21 Ibid.

22 Ibid.

23 Ibid.
thoughts, which can lead to emotional detachment. Examples of such events include sexual or physical assault, a natural disaster, or the unexpected death of a loved one. 24

**Psychotherapeutic Counseling** is described by rules that prevent any personal relations in the therapeutic bond for both parties involved. This type of counseling is two types of unconscious subtleties, conveyance and counter-conveyance.25

**Symptom Attribution** represents one’s beliefs about the possible causes of the symptoms. Researchers argue that when people face physical, cognitive, or emotional symptoms, they try to place the symptoms in well-defined categories and to label them as psychological, physiological, or normalizing (i.e., nonharmful) in nature. 26 Symptom attribution has a significant role in determining the course, the clinical presentation, and the outcome of the illness27. People who attribute their symptoms to a medical condition are likely to focus on their physiological sensations, to seek help from medical professionals, and to search for other medical symptoms actively. In contrast, people who attribute their symptoms to a mental condition are likely to seek the help of mental health professionals and to look for a constellation of psychological symptoms. There are no investigative studies for the roles of psychological, physiological, and normalizing symptom attributions in explaining group differences in help-seeking behaviors.

**Statement of Limitations**

Every attempt is to limit researcher bias during the implementation of this project; however, responder bias may occur given the contextual matter of the subject. Research is limited to the Church in this study with the condition of positive intent that the Church will

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24 Mental Health Definitions, 1.
27 Ibid., 392.
comply with instructions set in this study to prevent responder bias. The researcher’s ethnicity, personal ministry locality, and denominational affiliation delimited research restrictions.

**Thesis Statement**

Research presupposes that professional license counselors intellectualized the pastor's role concerning the Church. These perceptions denounce by several factors that separate the two professions: unfulfilled training, deprived communications, and fallacy related to the level of professionalism in the Church. Pastoral counseling equips ministers with skills and practices which help Pastors recognize behavioral and emotional changes in members. “Blending focus on spiritual oneness with God with good pastoral counseling skills empower pastors to intervene during a members’ mental health crisis.”

*What is Pastoral Counseling?*

Individuals may obtain both spiritual and psychological guidance from chaplains who have training through clinical pastoral education, spiritual directors, and clergy offering pastoral care. Studies reveal additional spiritually oriented inventions, including spiritual or religious empathetic Counseling, psychospiritual Counseling, Christian therapy, and religious Counseling.

Distinguishing pastoral counseling and other forms of spiritually oriented counseling produces complications; for instance, some research studies used the term pastoral counselor without exploring the definition, using the term interchangeably with religious or Christian counselor. According to the dictionary of pastoral care and counseling, “Pastoral counseling is defined as a twentieth-century phenomenon as the North American Protestant pastors

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29 Ibid.
incorporated new psychological information into their ministries that claimed a new genealogy based on Hebrew and Christian understanding of care.”.30 Religious and social changes restructured pastoral counselor practices, training, and identity.31 Observations denote that there is no universally accepted definition for pastoral counseling. 32

31 Ibid., 3.
Chapter 2
Conceptual Framework

Literature Review

In the article, Pastors’ Counseling Practices and Perceptions of Mental Health Services: Implications for African American Mental Health, the writers conducted an exploratory study to determine the practices, behaviors, and desires of African American pastors utilizing the first level service delivery model. Their research found a link between pastors who have optimistic views about mental health facilities and documentation of parishioner counseling sessions in the wider variety of subjects several days a month. Participating pastors in this study reported counseling their members on a wide range of subjects, the most common being marital and family issues (91.7%), spiritual problems (87.5%), sorrow (79.2%), and work problems (70.8%).33 While they currently teach on a range of topics, all but one of the pastors surveyed said that they could receive additional instruction in one or more fields. The minister’s topics selected the most were marital and family issues (72.9%), emotional (70.8%), drugs (54.2%), domestic and sexual abuse (45.8%), and sexual problems (45.8%).34 While work problems and spiritual issues were two of the most frequently reported topics of advice, they were two of the lowest perceived need for additional training. This finding suggests that pastors are more prepared than some other sources of mental health care to address these two subjects.35

34 Ibid.
35 Ibid.
The most frequently suggested issues in which professional counseling was necessary included marital and family difficulties and emotional problems, fields that were usually discussed with professionals of mental health. 36 Participants that were included in those areas improved mental health care, therapy, or planning. Interventions will focus on best practices to deal with social and emotional problems and implement them in religious communities. Pastors trained and licensed in professional mental health practices could include ways to deliver group-level services such as seminars or gatherings that might help lighten the time pressure that pastoral therapy can sometimes bring to busy pastors.

The self-efficacy of pastors around these issues directly affects the quality of care they will give their parishioners. An important aspect to consider is that pastoral care in the manner of traditional psychotherapy is not conceptual. For a long time, members of religious communities used pastors as a resource, and that is evidence of the effectiveness of their counseling. Conversely, individual pastors may not perceive their ability to handle severe cases passed on to them too confidently.”

The article, Religiousness, and Mental Health: Systematic Review Study, reviews recent empirical research to determine the role that religion plays in mental health outcomes. The most widely recognized problem is substance abuse, suicide, depression, and anxiety, impacting some 50 percent of mental cases.37 Such mental disorders are known to affect the public at large. The negative impact of the mental problems on the general public and economy could interfere with regular daily life and inflict misery on the sufferers and their families or superiors-now and again. Chronic depression may have a significant impact on people, families, social interactions

that may affect their day to day lives. There may also be an impact on their religious practices.\textsuperscript{38}

For example, practicing faith may be referred to as a treatment option over clinical treatment. There are numerous psychotropic medicines available for melancholy, nervousness, suicide, and abuse of addictive substances, and some are fruitful and helpful, such as treatment for intellectual conduct, relational psychotherapy, psychodynamics, and existential therapy.

Psychotherapeutic treatment for specific individuals is a powerful technique for treating mental dispersion.\textsuperscript{39} Through emotional and psychological literature, an increased passion for the influences of faith and otherworldliness on well-being is apparent. Even though religion intends to affect well-being, important research data suggests that strict practice with better mental and physical well-being is identifiable. Religiosity has been identified as an essential defensive tool for well-being; research has shown a secure positive connection between rigor and psychological well-being. That connection has spread across different populations, including teenagers, grown-ups, old, general community members, workers, and displaced people, undergraduates, the immoral, terrorists, lesbians, friends, and individuals with issues of mental health and character.

The article, \textit{Challenges to the Conceptualization and Measurement of Religiosity and Spirituality in Mental Health Research}, addressed religiosity and faith to clarify further how the religious experiences of individuals influence their attitudes, acts, and happiness generally. Nonetheless, contradictions in the conceptualization and interpretation of these patterns will affect the potential judgment of strictness and spirituality.\textsuperscript{40}

\textsuperscript{38} Abdaleati et al., “Religiousness and Mental Health,” 1930.

\textsuperscript{39} Ibid.

In the article titled, *The Gatekeepers: Involvement of Christian Clergy in Referrals and Collaboration with Christian Social Workers and Other Helping Professionals*, VanderWaal, Hernandez, and Sandman conducted a report to evaluate their subjects’ perception of Mental Health and Substance Abuse (M.H. and S.A.) requirements and their ability to comply and refer church members to medical care providers. Despite developing multiple effective clinical and psychosocial approaches aimed at neutralizing the effects of psychological distress and drug abuse, nearly 66 percent of all people, despite reported mental well-being disorders, are not looking for treatment. Social services usually offer social health and drug abuse service administrations. Barriers to individuals pursuing psychological well-being and drug misuse recovery include cost concerns, embarrassment surrounding psychological well-being issues, ignorance of psychological well-being issues, bullying over practices, and numbness over treatments. People in the Church are more likely to look for ministerial assistance than others.

The article concludes that some members of the clergy within the Church want to work with experts to help. There is an ambiguity in allusion to their eagerness and comparison examples. The Christian clergy has a significant role to play in recognizing people with mental health and substance abuse problems and providing education, support, and referral to the care needed. Researchers conducted an online study with over 200 Christian clergies from 50 + churches investigate their views of substance abuse and mental health conditions and their willingness to cooperate and refer members of the Church to professional service providers. Nearly two-thirds believed members of the Church typically feel more secure seeking pastoral support than turning to professional aid. Many clergies indicated that if they had a mental health or substance abuse problem, they would possibly refer church members to a therapist, especially
a Christian psychologist. Such findings show that the parishioners with the disability would receive medical care, help, and guidance from the clergy.

Social service workers commonly provide mental health and substance abuse treatment services. A 2006 survey sponsored by the National Association of Social Services notes that "Social workers in behavioral health are the primary specialization sector within the frontline social workforce with mental health being the most prominent (37%) specialty research category of social work." Social workers are the nation's largest group of professionally qualified mental health service providers providing more mental health services than psychologists, psychiatrists, and psychiatric staff combined, according to the Drug Abuse and Mental Wellbeing Care Administration.

Barriers to people seeking M.H and S.A. include financial issues, mental health stigma, denial of mental health problems, personal shame, and lack of treatment options. Possible reasons for the low rate of structured mental health services received may be due to the minimal level of help that clients receive.

Most people seek assistance from their clergy. Two studies cited in the article reviewed found that the treatment from priests were sought by between 25% and 40% of people. Evidence from the National Comorbidity Survey has found that, in a given year, almost one-fourth of those seeking mental health support from the clergy have a severe mental illness. However, most of these individuals are seen only by clergy, not by mental health professionals or other health care providers. Many members of the Church are more likely to seek help from

41 Ayalon and Young, *Racial Group Differences in Help-Seeking Behaviors*, 392.

the clergy than others. Analysis of data from the General Social Survey shows that regular church leaders, religious literalists, and the elderly are all the more likely to seek clergy as a source of advice, particularly assistance. Americans see the Church as a less suitable sources of assistance for more severe problems such as autism and for people who may be a threat to themselves or others. 43

The clergy needs to be aware of their shortcomings and make referrals where possible to trained mental health professionals. One study showed that some clergy has difficulty identifying emotional distress or suicidality, especially in comparison with other professionals in mental health. 44 Other scholars have expressed concern about whether clergy can properly recognize people who may pose a risk to others. 45 Through consciously serving the community's mental health needs, churches will help to remove the cultural stigma of mental health and substance abuse programs. Research suggests that individuals attending churches who have a positive attitude towards mental health services have more favorable attitudes towards obtaining assistance, especially in minority communities. Definitions of such church-based services could include encouraging community groups to take place inside the Church, allowing social workers and other supporting people to make short lectures or weekend workshops in the Church, offering adequate counseling services within the Church, or hiring a case manager to make service referrals.

While some clergy has expressed a willingness to collaborate with helping professionals, there is a discrepancy between their willingness to refer and referral patterns. Consequently, a more thorough understanding of the factors influencing their willingness to make referrals is

44 Ibid.
45 Ibid.
important. Besides, greater awareness will lead to the development of programs designed to improve access to the mental health and substance abuse resources that are required.

Representatives from the Kent County Michigan community mental health center and local clergy met in April 2008 to discuss several mutual concerns, including the low number of people receiving M.H. and S.A. treatment, particularly in the Black and Hispanic communities, and the lack of availability of services and connections to M.H. and S.A. treatment in the community. As a result of this meeting, the primary authors, together with representatives of the CMHC and local clergy, developed a survey to assess clergy perceptions of M.H. and S.A. problems in their churches, their actions in the face these challenges in their congregations, and their willingness to refer congregations to professionals.

This study concludes that Christian social workers have a unique opportunity to provide the clergy and their congregations with qualified, socially informed training and education. Social workers should communicate with the clergy before offering such help and seek their support in designing and delivering curriculum and educational materials. Besides, Christian social workers can strengthen connections with religious leaders by providing additional training in mental health education and collaboration, especially among less educated and minority clergy.

Another meaningful way for Christian social workers to help churches address mental health and substance abuse challenges is to provide these congregations with culturally competent counseling services. Social workers provide most of the professional mental health care, as noted earlier. Christian social workers will continue to look for ways to increase the use of mental health services within the religious community, particularly within ethnic minorities. At the same time, churches scan their communities for Christian counselors. Collaboration with
the clergy, however, is one way of removing some of the current obstacles to mental health services and increasing the opportunities for culturally competent treatment. Improving these collaborative relationships could go a long way towards ensuring that people with M.H. and S.A. challenges receive the assistance they need in a relationship that values their faith and provides the adequate treatment.

The article *The Integral Role of Pastoral Counseling by African American Clergy in Community Mental Health* mentions that little is known about pastoral counseling work of pastors of African American churches.  

There were ninety-nine pastors that participated in this study and spoke directly about their approaches to psychological issues within pastoral counseling. Face-to-face interviews were held at various settings and locations which are convenient for the participants. The interviews utilized a structured format that included open-ended response opportunities. The interview duration ranged from 45 minutes to six hours; the median interview duration was 90 minutes. The pastors in the research offered demographic statistics about their churches and themselves as well as identifying their structured and continuing education, including training in counseling. They describe a tendency to pray and reference the bible in their counseling sessions. One of the main problems the pastors identified among their members is a faulty relationship with God as a major cause of mental illness.

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46 John Young, L., Ezra E. H. Griffith, and David R. Williams. “The Integral Role of Pastoral Counseling by African-American Clergy in Community Mental Health.” *Psychiatric Services* 54, no. 5, 688

47 Ibid., 691

48 Ibid.

49 Ibid.
Another identifying issue within the congregation is stresses in living and early family relationships.\textsuperscript{50}

African American churches promote mental health in the community.\textsuperscript{51} The data from this study make clear the need for supporting the mental health promotion efforts of the African American clergy.\textsuperscript{52} The results in this research study add to the understanding of the structure and level of clergy involvement and the range of problems addressed by clergy in their daily work.\textsuperscript{53} For example, efforts to enhance the continuing education available to them would contribute greatly to the quality of services they are providing.\textsuperscript{54} Finding functional structures and support requires some creativity.

The clergy's pastoral counseling work in both urban and rural settings is ever-growing. Since the clergy's role is now known to be expanding, effectiveness is becoming a crucial issue. Additionally, expanding parallels to include the African American clergy in remote areas would be informative. Efforts to improve the continuing development available to them would provide a significant contribution to the quality of the services they provide. It takes some ingenuity to identify realistic support structures. In this regard, responsible bodies, including church authorities, seminary teachers, and foundation boards, may all contribute to its growth. The results presented here provide a basis and direction for the support of faith-based organizations, both public and private. The increasing pressure on public and private mental health care services may require that secular mental health professionals be integrated with that of their

\textsuperscript{50} Young et al., “The Integral Role of Pastoral Counseling,” 691.

\textsuperscript{51} Ibid., 692.

\textsuperscript{52} Ibid.

\textsuperscript{53} Ibid.

\textsuperscript{54} Ibid.
colleagues in the African American clergy. These findings and possibilities emphasize the need to study the African American population's health-promoting resources, including the role of the Church. Religious involvement, for example, might support behavior that is more conducive to health. Indirect health benefits can come from Church and group involvement. They may help share religious culture between counselor and client. Also, the African American clergy's ability to make mental health recommendations adds to the resources the African American community has to offer.

The article, “Spirituality and Religion in Recovery: Some Current Issues,” provide evidence suggesting that symptom-related stress may lead to increased use of religious coping methods for some patients, and over the longer term, it reduced the severity of the symptoms, as demonstrated in fewer hospitalizations. In the psychiatric hospital study, both public faith worship and private spirituality were associated with depressive symptoms that were less intense. Those who attended service regularly also had shorter average stay periods in the hospital and higher life satisfaction compared with less regular or non-attendants. That subjects repeatedly pointed out that religion and spirituality can serve as essential recuperation tools.

Faith and spirituality are among the most outstanding sources of support to many people served by public M.H. and S.A. services. For example, in a Los Angeles area, a survey of people diagnosed with severe mental disorders, over 80 percent indicated that they used religious beliefs or behaviors to cope with everyday problems, a percentage that is more significant than that seen in many general population polls. Also, 65 percent indicated that religion helped deal with their


56 Ibid.
psychiatric symptoms to a moderate or large degree. These religious activities are the "most significant things which kept them going" for 30 percent of the respondents.57

Some recent studies have started to explore the correlations between specific degrees of religiousness to spirituality and indices of mental health more thoroughly. Patients with a higher frequency of the symptoms and lower overall performance were more likely to use certain religious activities such as prayer and reading of the Bible as part of their coping. Furthermore, these persons relied on divine therapy more when their conditions deteriorated and reported fewer hospitalizations than the previous year.

This article addresses emerging views on the role of faith and religion in healing from severe mental health issues. Public views of the mental health practitioners from secular and faith-based organizations are examined, taken from a variety of discussion groups and workshops in addition to the published literature. Consumers in the healing process recall the beneficial and burdensome functions of religion and spirituality. From the viewpoint of mental health services, the experts there express both optimism for and frustration with those realms. Key recommendations about the appropriate place of spirituality and religion in psychiatric rehabilitation and related supports emerge from every perspective. These latter studies are more similar to the large body of research that examines the relationships between spirituality and well-being in community samples and among people with medical illness. However, there is a growing consensus that many aspects of religion and spirituality are favorably linked to welfare metrics. This research addresses links between certain aspects of spirituality and mental health; it may provide indirect evidence that is useful in working with people diagnosed with severe, persistent mental disorders.

Findings involving affective disorders may be particularly relevant. For instance, medically ill elderly people who were diagnosed with depressive disorder found that intrinsic religiousness (following religion' for its own sake' rather than providing social or emotional support) predicted a longer remission from depressive symptoms. Other studies have reported similar relationships between some form of religiousness and fewer symptoms of depression.58 Fallot examined the role of religious coping methods in the control of stress. His research shows strong links between positive forms of religious activity and better mental health.59 Demographic factors such as attitudes and beliefs perceived as solidarity with God, seeking spiritual support from Christ or religious communities, and favorable moral views, temper negative situations with less pain, less depression and anxiety, and more positive effects. Spirituality or religion may be related to important sources of strength, support, and stability.

The practices of many religious or spiritual organizations have not only functional and emotional aspects but also impact moral perceptions. A culture that sees itself as rooted in friendship with the divine belongs to and seeks acceptance in it, and is often ignored, alienated, or stigmatized.60 Even if the spiritual experience and values are not directly related to an established religious community, they stress and encourage the development of the fundamental sense of connection with the self, with others, and with the supreme or the sacred.

Optimistic coping strategies for some users can lead to negative coping consequences for others, both religious and spiritual. Prayer or other religious rituals can become compulsive and interfere with overall everyday operations. The desires and concerns of customers have led to individual specific recommendations on the role of spirituality and religion in the context of

59 Ibid., 264.
60 Ibid., 263.
mental health services. Firstly, mental health programs, an approach that explicitly incorporates
the spiritual dimension of life, should adopt a holistic approach to both assessment and
intervention.

Approach faith directly, considering the understandings of spirituality and whether
religion or spirituality is important for individuals; challenge spiritual or religious history;
consider whether and how the consumer would like to have spiritual problems or priorities
included in their work. The individualized approach means that mental health practitioners
become aware of the many and complex ways in which religion can work in the lives of people
with mental health problems. Faith and religion can vary enormously in different times, contexts,
and in dealing with various types of problems and stressors. Many practitioners are very
optimistic that spirituality is theoretically an extended and visible component of mental health
services, but significant issues within mainstream and often critical professionals reoccur. Yet,
not all mental health practitioners have a hatred of faith; some are faith-based. Pastoral
Counseling teaches spiritual values with respect to the way someone faces harsh realities.
Nevertheless, even clinicians with a more neutral or positive recognition of religion, including
differentiated views to this topic, question if spirituality should have a more prominent position
in service delivery. Taking a view of the nature and effect of trauma on the lives of individuals
receiving health services, they distinguished between trauma-specific and trauma-information
treatment.

The effects of injuries and the recovery process primarily rely on trauma-specific care
such as ambulance and medical treatments like Eye Movement Desensitization and Reprocessing
(EMDR). Similar to these services, trauma-specific programs may solve a wide range of social
issues, but their trauma experience makes the programs hospitable, compassionate, and helpful
for trauma patients. One of the few epidemiological types of research carried out in the mid-1960s was group groups, Gurin and colleagues in 1960 showed that 42 percent of those who seek assistance with emotions were receiving support from clergy members, even more so than those who visited psychiatrists, mental health practitioners or some other occupation. This percentage dropped twenty-five years later in a follow-up report but is also very high (34%). 61

In the early 1980s, the Epidemiologic Catchment Area (ECA) report found that about 20% of the people seeking mental illness treatment had contact with clergy and other providers of social programs. Particularly in light of growing literature, it is essential to consider what clergy services offer mental health services. The priestly studies show that many individuals are not adequately educated in psycho-pathological understanding and severity and pastoral therapy.62

The pastoral ministers spend less than 10 percent of their time on this interpretation and because of their conflicting perceptions.63 Past studies suggested that the clergy transfers fewer than 10 percent of those with relational problems to other mental health professionals.64 Fewer the efforts to enhance the mental health of the clergy have had a positive impact on the quality of pastoral care, and healthcare professionals still lack teamwork.65 The findings of this study reflect the clergy's important role in U.S. mental health services. The results suggest that the use of clergy in the 1960s and 1970s has diminished.66 However, the use of the clergy increased in


62 Ibid., 666.

63 Ibid., 649.

64 Ibid.

65 Ibid.

66 Ibid., 663.
the 1980s and early 1990s, with about one-fifth of those with a mental health condition seeking priests the first time. The explanations for the national renaissance after decades of secularization remain unclear but are related to the increase of religious belief and behavior. Recent National Research results in October of 2000 also indicate a gradual decrease in outpatient sessions and a drastic increase in the use of mental health nonpsychiatric professionals and the alternative, self-help, and non-traditional types of mental health care.67

The article titled, Racial Differences in Attitudes Toward Professional Mental Health Care and the Use of Services, the study of the second section of the National Comorbidity Survey, explored the disparities in attitudes towards medical, mental health, and the use of mental health services.68 The study finds that African Americans had a more positive attitude toward mental health programs than Caucasians; however, African Americans were less likely to use mental health services.69 Once used, their views were less favorable than those of the whites.70 The goal of this research was to resolve this need by examining racial differences in attitudes towards treatment and their connection with mental health services in a representative sample of the U.S. population. Based on previous findings, the following hypotheses had to be examined: African Americans generally have fewer positive attitudes toward professional mental health care than the Whites; African Americans with a high incidence of depression similar to that of Whites but have fewer positive attitudes toward such care.71 Family income, which

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68 Ibid.

69 Ibid.

70 Ibid., 456.

71 Ibid., 457.
reflects economic resources allowing the use of mental health services, has been clustered at five annual averages.72 The distribution of household wealth over household income is uneven, and variables like ancestry cannot imply a strong positive association of wealth with employment, schooling, or profession proved in the stratified data sample.73 The household income mentioned in this article coresponds with the racial difference of those who can afford to seek professional counseling. The African American congregation will often times refer to their pastor as services at the church are often free, compared to professional counseling.

In the article, *Use of Clergy Services among Individuals Seeking Treatment for Alcohol Use Problems*, the research explored the frequency and features of people accessing religious treatment with alcohol consumption problems.74 From the state epidemiological survey data on drug and related conditions, 14.7% of people seeking certain drug-related services reported using clergy services.75 In a multi-variable regression logistic model, “Black persons, aged 35–54 years with a history of alcohol dependency, major depressive disorder, and personality disorders in their lifetime are associated with increased service likelihood.”76 Pastors can take advantage of training to identify problems with alcohol use and play a role in making referrals for care. The problem of alcohol use consists of behaviors of overuse, such as

72 Diala et al., "Racial Differences," 458.
73 Ibid.
75 Ibid.
76 Ibid.
heavy drinking, binge drinking, and psychiatric conditions operationalized in the Diagnostic and Statistical Manual of Mental Disorders.\textsuperscript{77}

The traditional description of pastoral counseling is psychotherapy conducted by ordained clergy serving as emissaries to particular faith groups.\textsuperscript{78} Clergy become pastoral counselors in a mechanism that combined mainstream clerical positions with psychotherapy training, culminating in certification by the American Association of Pastoral Counselors (AAPC) and related clinical credential associations.\textsuperscript{79} “Towards the end of the 1990s, this clerical model was challenged by shifts in culture, spirituality, and pastoral therapy practices.”\textsuperscript{80} The emerging focus on pastoral theology, which has historically promoted pastoral counseling, now questions the traditional practices by raising questions of gender, racial and ethnic diversity, internationalization, and the increasingly public presence needed for pastoral theology.\textsuperscript{81} Voices within AAPC raised questions about justice: pastoral therapy defined as an ordained profession omitted women, gay and lesbian counselors, some who were called to advise but not to ordination, as well as counselors from different Christian traditions.\textsuperscript{82}

Despite direct links with the agency, Christian groups and prospective customers have not understood what pastoral counseling is. When doctors began to study complex social environments, confusion became exacerbated. They had to share their particular knowledge at these different locations and distinguish methodologically from a wide range of other experts.

\textsuperscript{77} Bohnert et al, “Use of Clergy Services,” 345.
\textsuperscript{78} Townsend, \textit{Introduction to Pastoral Counseling}, 1.
\textsuperscript{79} Ibid.
\textsuperscript{80} Ibid., 2.
\textsuperscript{81} Ibid., 3.
\textsuperscript{82} Ibid., 1.
Unlike other topics, pastoral advisors have no scientific basis in support of arguments regarding particular procedures, methods, or outcomes.

Rules were adjusted to accommodate exceptions; however, key documents retained a Protestant clerical bias, in 2000, states that few university or seminary pastoral counseling programs expected graduates to be ordained or associated with the clerical office. Religious communities and potential clients have been confused about what is "spiritual" about pastoral counseling without specific references to the position established by ordination. The confusion became compounded when skilled educators started practicing in complex social environments. They had to express their particular presence in these new locations and to define themselves methodologically among a wide range of other practitioners. Spiritual practitioners, unlike other fields, have a little scientific basis to support their claim in specific methods, tactics, or experiments. Worthington noted about a quarter of a century ago that little understanding about how pastoral therapy varies from therapeutic counseling or benefits clients. Gartner et al. argued in a study of the pastoral literature between 1975 and 1984 that pastoral therapy did not develop as a definable discipline because it found empirical research to be negligible. As a result, there is inadequate research to identify interventions or prove effectiveness. Only 55 articles recorded any use of instruments or techniques for empirical research, most of which were of little value due to methodological shortcomings.

The research on clinical psychology shows a few scientific papers. Technical deficiencies have impacted less than half of these. A decade earlier, Henderson and Gartner noted, in 1991,

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84 Ibid., 2.
85 Ibid.
86 Ibid.
that "virtually nobody has a structured curriculum for empirical research on pastoral therapy."\textsuperscript{87} This has contributed to a "research vacuum," which means that both ecclesiastical and public structures are indefinitely blocked.\textsuperscript{88} Failure to undertake empirical research implies that existing pastoral counselors do not have clear definitions of clinical methods, can not empirically identify or describe core concepts, have a little part in the development of new public care theory, and are not exposed to important research in faith and mental health. Worthington’s research employed a validated hypothesis that identified the pastoral consultants' actions as a qualitative scientific definition, their social environments, and experiences as "pastoral" and how they say that they offer a specific contribution to the field of public mental health. The aim was to define the limits of the first philosophy of pastoral counseling, irrespective of contributions to psychotherapeutic templates. “This study was developed with established qualitative methodology (theory-based), attention to a multitude of forms of data interviews, affidavits, interpretive consultations, and focus groups), attention to questions of qualitative validity and established coding, and the observation that the greatest amount of qualitative pastoral research lacks methodology.”\textsuperscript{89} Many results of this study were previously published.

A quarter of a century ago, Worthington recognized that little understanding regarding practical counseling rather than professional advice or helping customers. Gartner et al. stated in a 1975-1984 study of pastoral literature that pastoral therapy was not a certain science since the scientific analysis was negligible. No research was carried out to identify or explain improvement protocols in the event of a failure. Only 55 publications study empirical research methods or procedures, most of which were of little interest because of methodological

\textsuperscript{87} Townsend, \textit{Introduction to Pastoral Counseling}, 2.
\textsuperscript{88} Ibid.
\textsuperscript{89} Ibid.
deficiencies. In the clinical therapy literature, there are few scientific papers. Analytical shortcomings influenced less than half of these.

Grounded Theory (G.T.) is a qualitative research methodology designed to analyze individuals and structures. 90As a testing technique, G.T., will not test existing theories. As an alternative, an explanation scheme or intermediary theory is used to evaluate raw data and to create a gradually systematic, continuous comparison approach.91 These take place by simultaneous data collection and analysis, two-stage data coding processes, comparative methods, memoranda writing aimed at improving empirical analysis, sampling for refining new researchers' theoretical ideas, and incorporation into the theoretical framework. The grounded theory principle starts with a limited volume of data from a criteria-based sample.92 The first evidence for this research came from two sources: interviews from five pastoral advisers and five written statements of pastoral identification with approved applications from the American Association of Pastoral Counselors (AAPC).93

Applicants are chosen based on competence as medical clinicians, Association of Pastoral Counselors (AAPC) fellow, or professional associate with active clinical practice. The survey goal was to achieve maximum variability, class differences, age, geographical region, and to address the operational position currently. Interviews are necessary for the office of professional advisors. This involved significant visits to all nine AAPC areas with respondents. The consultation in vivo with pastoral counselors offered valuable historical details on the nature of procedures and structured representations for pastoral counselors.

91 Ibid., 2
92 Ibid., 3.
93 Ibid.
Community practitioners generally described themselves as state licenses, Licensed Marriage Family Therapist (LMFT), License Professional Counselors (LPC), License Clinical Social Workers, or Psychologists (LCSW), and referred to themselves as "economic theologians" who mixed spiritual values with social and professional services. 94 Personal therapists and the most various whose jobs rely on the reimbursement of third parties. Many identified themselves merely as theological advisers, many as state-licensed practitioners concerned with spiritual issues, and some as clinicians, without regard to religious or pastoral matters. 95 Another observation was that in areas where religion is of little prevailing cultural importance (North-Eastern, North-West, and South-West America), respondents were more inclined to describe themselves as spiritual counselors and philosophical consultants in the workforce and use religious symbols. 96 Several people noted that they are differentiated from other doctors by transparency. For starters, the clergy is considered to be psychiatric counselors by way of a procedure incorporated by the Association of Pastoral Counselors (AAPC) into traditional clerical positions and psychotherapy instruction. 97 This clerical trend experienced shifts in culture, religion, and religious counseling in the late 1990s, which this information was noted in the introduction of Townsend’s research report. In the field of contemporary theology, which traditionally promoted theological rehabilitation, the orthodox approaches were questioned by the concerns of sex, race, and ethnic diversity. 98

95 Ibid.
96 Ibid., 6.
97 Ibid., 3
98 Ibid., 11.
Conversely, throughout regions where religion has a strong cultural meaning, respondents overwhelmingly opposed religious symbols. They did not recognize themselves as spiritual or religious unless questioned or affiliated with specific religious cultures that provided them with references. A small group of theological leaders saw each other as evangelists who gave unchurched people the light of God. In the sample, pastoral counselors also underpinned the expertise of training with the pursuit of psychiatric competence guided by personality, which blurred the strong reciprocal connections between practice, development, and identity. Training and integrity integrate deep into human schooling and service practices. Now keep in mind that this is an analysis of the connection between mental health and Pastoral Counseling. The reader will see in the survey results when individuals are questioned about their psychiatric competence in relation to religion; individuals will often refer to a religious connection.

Community events have a platform on mechanisms of collaboration and recognition. These activities reflect those principles, moral beliefs, ethical standards, and requirements for customer service that are part of a consultant's formal understanding. Many individuals who have interacted and shared their teaching practice via long-standing relations showed this. Pastoral counseling requires a therapeutic relationship that is systematic and qualitatively special to many practitioners. The principle expands the reach of the psychological method by focusing on the use of oneself in counselor therapy. Many of those interviewed alluded to "pastoral engagement" as a relationship that stretched beyond clinical experience and served as "the avenue of grace." The question also drew respondents to the position of the therapist's integrity or ability to sustain his professional image. The pastoral involvement often explained the execution of religious

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100 Ibid., 8.
101 Ibid., 10.
conferences or extra-session encounters, such as marriages or funerals, hospital visits, or home gatherings, in order to solve suicide threats.

Reflexivity, a central principle of post-positives studies, calls on scientists to ask whether they are rooted in science and knowledgeable facts and interpretation of a Black, Catholic, seminary, pastoral counselor taught in non-traditional contexts in this situation. The joint consultants and the confirmatory interview lead to the analysis of how one's own experience and social status as the primary investigator could influence perception and hypothesis development.

The authors Liat Ayalon and Michael Young investigated the disparities in Black and White activity and the function of cognitive-affective influences as mediators for these variations. A sample of 70 Black students and 66 Caucasian population students completed an updated multidimensional health care locus, a symptom interpretation questionnaire, and a demographic comparison. Among White College graduates, medical and social services were used slightly less often, and faith activities were somewhat more available. The scientists have clarified disparity in religious actions by confidence in God's powers and symptom normalization. The cognitive-affective factors studied did not consider differences in psychological actions. The authors argue that cooperation between mental health and religious services is likely to help Black University students meet their needs. To date, several researchers have sought to understand these differences in the steps to assist in looking for the apparent need and social and spatial limits as explanatory variables.

Nonetheless, insurance-related Black people are far less likely than Whites, who have the same benefits, to have ambulatory mental health care. Programs that are historically open to

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102 Ayalon and Young. "Racial Group Differences,” 391
103 Ibid.
104 Ibid.
supporting ethnic minorities often do not operate in contrast with financial and geographical obstacles. Others suggested that the tendency of Black people to rely on indirect signals and that social institution hamper their access to mental health services. Although the majority of scholars have tested three different aspects of medical, psychological, and religious aid-seeking practices in the current study, they have also examined all three fields to see whether the behavior of both populations varies in their search for help in the three areas. Moreover, the role of cognitive-affective factors in understanding these differences has been hardly given much attention following a well-documented disparity in traditional healthcare indicate behaviors between Black and White. Such principles reflect values and ideas for the perceptions of one's planet. The majority of researchers focused on access obstacles such as financial, geographical, mobility, or perceived needs, with no account given to the role of cognitive-affective factors in establishing and maintaining the support gap between the two groups. It is especially important to be aware of the function of cognitive-affective variables because they are likely related to the cultural and social variations between them. The findings would, in turn, help to develop fiscal, non-service, and psychiatric programs to serve the specific needs of Blacks. There have been many potential reasons for the high use of healthcare resources in Black mental health, including Black people who prefer to focus on somatic problems than psychiatry. Black people seem to have more confidence in and appreciate drugs than mental health professionals and derogatory mental stigma. Nonetheless, the role of symptom perception and attitudes towards mental health clinicians is not empirically investigated. Nevertheless, the results of the study did not support a higher incidence of Black mental illness.

Essentially, determining the magnitude of help-searching operations using a self-reporting study with retrospect is less than ideal. As always, the evaluation of activities requires
support from the review of history when various challenges restrict the analysis to each organization. In addition to detailed reports, diaries can provide a concise description of these activities.

This study has many risks. However, while the employment rates for participants were similar, they did not control several other socioeconomic factors. Several socioeconomic status measures will be used for future researchers to calculate discrepancies in help-seeking behavior among ethnic minorities. Of reality, there are all risks and benefits of studying a non-clinical setting. The downside to studying a non-clinical community is that different forms of study do not preselect applicants. The downside is that a non-clinical group requires fewer social welfare standards and differs from a clinical population. Nonetheless, in this study, they noticed a fairly high percentage of students in both groups to have a significant psychological need and a broad range of answers. When researching both therapeutic and non-clinical classes, we have a better understanding of the differences in the actions of help-seekers. Ultimately, retrospectively, it is less than desirable to measure the level of self-reported help-searching behaviors. The assessment of behavior that needs support by evaluating the past of different organizations is, as always, challenging and limits the study to specific institutions. A concise description of these activities may give detailed reports. Compared to earlier studies that did not consider the role of cognitive-affective variables in behavioral quest group differences, they tried to define multiple possible cognitive-affective variables to explain the help-seeking gap in the current research.

Theological Foundations

Spiritual leadership skills must be acquired to maintain one accord with God if pastoral counseling is profound. Some may wonder, what is the position of the leader? Leadership is one of the most widely viewed but least understood places in the world. "Leadership is the
persuasion process through which an individual leads a group to achieve goals shared by a leader. Pastoral counselors are God's appointed members. The main purpose of shop counseling is to serve God's intent.

The following base for a spiritual counselor is a disciple Discipleship is Christ's devotion. Discipleship is one of Christianity's fundamental principles, and without it, there is no road. Since Jesus Christ, discipleship is the same as following one's course. Pastors need to follow God's direction with faith leadership skills to maintain a relationship with God and ensuring that faith therapy is successful. Some may ask, what is the member's role? Leadership is one of the world's most widely regarded but least understood places. Leadership is the convincing way an individual leads a group to attain ideals decided upon by a member.

The next pillar for a spiritual counselor is discipleship. Discipleship is Christ's commitment. Jesus lives, and it is necessary to follow him. Discipleship is one of Christianity's fundamental principles, and there is no path to follow without it. After Jesus Christ, discipleship is the same as making one's path. Pastors must follow God's course from which they ordain.

Pastoral Counseling assists people through a social interdisciplinary practice environment for religious and non-religious concerns, in particular, philosophy and human/sociology. From now on, pastoral psychology research will mentally prepare worship and church gatherings. The representative, who is essentially a member of the government, talks with the Church. In friendship, celestial estimation is a significant issue. Peaceful thinking and encouragement are thus characterized by building a relationship with God and praying. Such two subjects are everyday religious rituals in consideration of pastoral care, which affirm the strong experience of this government. Matthew 22:37-39 105 reads, " Jesus said unto him, Thou shalt love the Lord thy

105 Unless otherwise noted, all biblical passages referenced are in the King James Version of the English Bible (KJV).
God with all thy heart, and with all thy soul, and with all thy mind. This is the first and great commandment. Furthermore, the second is like unto it, Thou shalt love thy neighbour as thyself."

Each pastoral counseling experience builds up the relationship between the counselor, counselee, other involved individuals, and God.

Pastoral counselors must train to know various methods of counseling. Colossians 1:15 “Who is the image of the invisible God, the firstborn of every creature.” The pastoral care movement is also a training or education movement that transferred the idea of a charismatic pastoral counselor to a professional and competent one. Exodus 15:26, “And said, If thou wilt diligently hearken to the voice of the Lord thy God, and wilt do that which is right in his sight, and wilt give ear to his commandments and keep all His statutes, I will put none of these diseases upon thee, which I have brought upon the Egyptians: for I am the Lord that healeth thee."

The apostle Paul in this verse cites the experience of his or fellow ministers who were going through affliction. 2 Corinthians 1:4. It reads, "Who comforteth us in all our tribulation, that we may be able to comfort them which are in any trouble, by the comfort wherewith we are comforted of God." Many troubles and afflictions of the saints in this life, but it is God's Will to comfort those going through tribulations. 1 Peter 5:2 reads, "Feed the flock of God which is among you, taking the oversight thereof, not by constraint, but willingly; not for filthy lucre, but of a ready mind." The pastor of the Church is the shepherd. A pastor is the master of the flock who protects, leads, and feeds the flock with the word of God. These duties are performed in ways like preaching, setting a godly example, and providing spiritual advice. Although the student community is generally aware of low levels of need and therapeutic assistance, the current results show that 24% of Blacks and 30% of Whites reported symptoms of depression
close to or above the average standard of outpatient psychiatrists.106 There was also heavy use of psychological or social services: 34% of Blacks and 50% of white people registered to receive psychological or social services at least once in the previous year.107 Religious services are most often use for both races, with 87.1% of Blacks and 74.2% of Whites reporting that they utilized religious services at least once in the past year.108

The current premise that Black college students are more likely than white college students to use religious services is in line with arguments that black religion plays an important role in Black life. Interestingly, in the present study, it was found that religious services are high frequency, but that priest services are relatively low, the context in which the question might have given rise to different answers. Immediately after a set of questions about religious beliefs and the importance of faith, religious services asked, whereas the question of clerical appointments included other medical and mental health concerns. Blacks appear to use religious services for spiritual or religious purposes, but not to alleviate their distress. This conclusion supports the fact that the extent of psychological distress does not affect actions in the current study, particularly religious or clergy. Likewise, research suggests that ethnic minorities, notwithstanding their high religious engagement, tend not to seek religious services when they are distressed.


108 Ibid., 397
Chapter 3

Methodology

Introduction

Religion is a significant component in the lives of many people. It makes sense for the people of a particular faith to seek support from the religious community. For all the different types of therapy used for mental illnesses, it is essential for the client and the therapist to establish trust, empathy, and understanding. The reason why many people prefer to seek help from religious institutions is that their religious leaders are familiar and trustworthy. Pastoral counseling is an opportunity for the church leaders to weigh in the mental health issues affecting their members. They have to align the counseling with the spiritual principles established in the church\textsuperscript{109}. Pastoral counseling for mental illnesses is unique because when compared to other forms of discussion therapies, the counselor and the patient already are comfortable relating with each other from the beginning. However, church leaders are available to offer their services and counseling for any person who reaches out to them, irrespective of their religion or past experiences. Pastoral counseling is provided by the pastors who have been trained both spiritually and psychologically aspects.

This chapter will describe the research methodology used in the study, justification of the sample selection, and the variation of the responses amongst the respondents within the sampled group. It will also describe the procedures which were used to design data collection instruments as well as a description of how they were used to collect data for the study. The chapter will also provide an explanation of the data analysis methods and those used to gather statistical

information and making the connections and relationships between the data collected in the study and the information found in the literature review, the research questions, and the null and alternate hypotheses.

Most of the research about pastoral counseling and mental health uses qualitative research approaches to make conclusions on the ease with which people use church leaders for mental health counseling. A substantial number of Christian based articles that are reviewed in this dissertation are both qualitative and quantitative, and the articles provide evidence that congregations will attend pastoral counseling sessions for mental health issues will varied response rates. Most of the articles also state that pastoral counseling uses traditional psychotherapy and supports the counseling methods used with faith and faith-based resources. Pastoral counseling works to provide goals, such as enlivening the mind and revitalizing the body. The pastors also want to ensure that the patients have a deeper relationship with God and nature and surroundings. When the pastoral team has these tools at their disposal, they are a helpful resource to their congregants addressing their mental health issues. Sociological studies, on the other hand, uses a quantitative approach by incorporating statistical information/data on the number of people who seek pastoral counseling for mental problems. Since most of the congregants are free to talk about their experiences, and there is a little stigma to mental health counseling in churches, quantitative data will mainly be used in this research.

Research Methodology

The methodology used in this research is both qualitative and quantitative, which collects the data and interprets it to understand the trend in people seeking pastoral counseling for their mental problems. The quantitative research aims to answer the null hypothesis and hence uses a descriptive research design. Qualitative research, on the other hand, seeks to understand the trend
in people using pastoral services for mental illness counseling. It helps to establish the themes for the survey. The disadvantage of the quantitative method is that it is different in every approach because of it being a survey. At the same time, the quantitative method garners more data. The descriptive research design was used because carrying out a longitudinal study that would include the following up of the participants for a long period would not fit in this research. It is an effective strategy when working with a group of people considering their attitudes, values, and beliefs as well as taking less time and incurring a little cost.

The qualitative results in this paper were drawn from the congregation in Deliverance Center for all Nations’ Church. The responses were gathered from administering questionnaires to a selected sample of the members of the church. The questionnaire contained 21 questions that were structured as per the theme of pastoral counseling in mental illness cases. The responses and the information received were correlated with the insights from the literature review.

The approaches used in theological studies and papers follow the qualitative methods, which offer insights on the mental problems affecting the congregants and the help they receive from the churches. Therefore, it is important for this research to include first-hand information from the participants as well as information from the literature review on this topic. Therefore, the broad interpretations of the qualitative research were made concrete using the figures provided by quantitative research.

Qualitative data was obtained from the members of the Deliverance Center for all Nations Church. A survey questionnaire is an appropriate form of obtaining both qualitative and quantitative data because the information collected is standardized. However, the design of the questionnaire needs to be carefully considered because the method is rigid in terms of the information collected. Since the topic is sensitive, giving the people a cross-ended questionnaire
will enable the respondents to participate in the study privately and hence give them the liberty to provide accurate information.

Data Collection Method

Data collection in this research considers the secure method of having members of the Deliverance Center for all Nations Church take a survey. Since this is a secure anonymous survey, and the collecting method has to limit bias to support meaningful data, no members who have knowledge of the survey questions or who are actively a part of data collection cannot interact with the pastoral team as well as the participants of the survey within the church environment. The student nor any members of the research team cannot take part in face to face clarification and take the subject further, increasing the necessary information and bringing out a number of hypotheses and research questions, only this clarification is strictly done through survey questions. The sample selection is smaller and makes the focus be on a few candidates. The benefit of using the questionnaire is that it is structured, and the probability of error is low.

Grounded Theory Methodology

The qualitative research was conducted using the grounded theory methodology. It is a way that helps to move from individual knowledge to collective knowledge\textsuperscript{110}. It was introduced into the research domain in the 1960s, where the discovery of theories from data collected was emphasized. The only parts of grounded theory methodology that are excluded from this research is focus groups and interviews. It has both positivism and constructivism. The positivist position is a result of the experience human beings have and the experience which comes with the understanding of the imperfect nature of people. At the same time, the constructivism philosophy

\textsuperscript{110} Wiesche et al. (2017). Grounded theory methodology in information systems research. 685.
is as a result of the human experience as compared to the culture and the external influences. Therefore, the research on pastoral counseling on mental illnesses was conducted using the grounded theory. It used the constructivist approach to understand and acknowledge the influences and the factors that lead people to seek pastoral counseling when they are faced with mental problems. Therefore, the research sought to conventionalize the experience of all the participants and make conclusions based on the responses given.

The Researcher

Although the researcher is a religious person, she is not a member of the Deliverance Center for all Nations Church where all the participants of this study were members; hence they had no direct relationship with the researcher. Therefore, there were no issues that could present a conflict of interest that could bring bias in the study. The researcher is trained in the skills that are required to carry out the designed study. Some of the skills include good communication skills, proper analysis of the questionnaires, and research methodologies.

Data Sample Background

The Deliverance Center for all Nations Church was chosen for this research to help have a focused case study of the congregants from the same church. The church is dominated by African Americans and has more than 1000 members. The current pastor is mandated to be the pastor and is the general overseer in charge who sits as the chairperson in the church Board of Directors. As a private institution, the church has its own by-laws, which provide the guidelines on how the congregation is run. As a result, there are small group ministries that are meant to ensure a successful model of operations. One of these groups is the pastoral counseling team headed by the general overseer. It is responsible for guiding and counseling people with different issues such as family problems, mental illnesses such as anxiety, depression, and bipolar issues.
The church leadership is mandated with the responsibility of maintaining discipline and ensuring that all the activities are as planned. However, there have been some controversies related to counseling and the church, which is why they are interested in this research. There have been cases of members of the congregation leaving the church to seek help that was lacking from their spiritual leaders when they were dealing with mental illness problems. With a huge membership in the church, it is important to understand the feelings of the members on the services offered by the pastoral team and whether this approach to counseling is good for them.

Study participants

The sample of the study participants was drawn from a population of churchgoers in the Deliverance Center for all Nations Church in the United States. These were people who could have used pastoral counseling for mental problems, those who knew of a relative, or those who have not accessed such services. The church members were those who could be classified as fully identifying with this congregation. All of the participants were fluent in English, although it was not their native language. An age limit of 18 years was set to ensure that all of them were adults. Some of them were college graduates, while others were high school diplomas holders.

The recruitment of the participants was done on a voluntary basis. The church, through the request of the researcher, requested those who were willing to take up the survey questionnaires and fill them after the service. The researcher then acquired their names and contacts and contacted them through SMS for communication. The participants were then asked to respond to the survey questions and either agree or disagree to be part of the research after reading what it was all about. Those who accepted signed a consent form and proceeded to acquire the questionnaire for responding to the survey questions. The research anticipated having about 200 to 300 people. However, at the end of the day, 106 of them agreed to participate.
Sampling

The participants selected may or may not be restricted to a single site, but for this research, the participants were restricted to be members of the Deliverance Center for all Nations Church for convenience and ease of administration of the questionnaires. The other major requirement was that the participants be above the age of 18 years because the researcher did not want to involve minors in his study. For this reason, purposeful sampling was used to ensure that those who were under 18 years were not included. Purposeful sampling is used when the researcher wants to gain particular information in a given sample of people. In order to shed more light on pastoral counseling and mental illness, the participants had to meet the following requirements;

- Be above 18 years of age
- Be a member of Deliverance Center for all Nations Church

To recruit the participants, the researcher gave the questionnaire to those people who seemed to be meeting the criteria and invited them to participate in the survey. The purpose of this first set of questions was to share the reasons for the study and what the participation would be like. A consent paper from the university was also attached whereupon accepting they were signing on it. Of the 200 people selected for the survey, 94 did not respond, and 106 agreed to participate. They were given the second copy of the questionnaire upon receiving their consent forms. Each of them was allowed to go through the questionnaire for clarification before handing it over. After receiving all the questionnaires, the information was analyzed, and a draft model for pastoral counseling on mental illnesses was developed. It included the perceptions people hold and their effectiveness.
Characteristics of the Participants

As earlier mentioned, the participants needed to fulfill two requirements. They were supposed to be available for the study the researcher was carrying out, as stipulated by Creswell\textsuperscript{111}. Screening criteria were developed, and hence the participants composed of adults who were of any ethnicity, although the majority were African-American, bearing in mind that this was a church located in an area where most people are black. The majority of them were females, with a small percentage being male.

Instrumentation

In any data collection process, it is important to maintain the reliability and accuracy. In this research, to achieve these aspects, the survey questionnaires were designed to be cross ended to obtain the required information from the respondents. The 21 questions were designed to obtain data for various purposes. Therefore, to ensure that accuracy and reliability are achieved, the questions were formulated using the guidelines provided by Creswell, who provides guidelines on the right format for survey questions. The disadvantage of this method, as stipulated earlier, is that the responses received and their accuracy depends on the respondents' faithfulness. However, to ensure that the responses were reliable, the questions were formulated against specific themes and topics established by the researcher. The researcher applied some precautionary measures to ensure that reliability is maintained. The following steps were used to ensure that reliability was maintained.

I. Ensuring that each question is easy to understand for the respondents

II. The participants can understand and interpret the question as per the intended purpose.

III. The question items have an intuitive relationship with the topic of the research themes.

\textsuperscript{111} J. W. Creswell & C. N. Poth, \textit{Qualitative Inquiry and Research Design: Choosing Among Five Approaches}, (Sage publications 2016).
The intention behind the questions is clear.

The survey questionnaire consisted of 21 questions, which were divided into three sets. The first set was on the personal information of the participants, which included the age of the participants, their gender, and ethnicity. It also contained information on whether the participant has struggled with mental illness. From this information, the researcher was able to establish the rates of the mental illnesses in the church, the gender of the participants, and their ethnicity. The second set is on the pastoral counseling in the church. The third set of questions is on what the participants think of the services offered in the churches for mentally ill members of the church. The survey was set to be undertaken privately; hence the understanding of the participants on the questions was crucial. Some of these questions were designed to understand the role the pastoral team plays in providing mental counseling to the congregation. All the 21 questions were structured around the established themes. Table 1 shows the themes used in this study.

Table 1. Research Themes

<table>
<thead>
<tr>
<th>Theme 1</th>
<th>Attitudes towards Pastoral Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme 2</td>
<td>Competency of pastoral counseling</td>
</tr>
<tr>
<td>Theme 3</td>
<td>Confidence of Congregants in Pastoral team</td>
</tr>
</tbody>
</table>

The responses from all the themes of competency and attitudes towards the pastoral counseling were all on a 5-point scale: Strongly Agree, Agree, Neither Agree Nor Disagree, Disagree, and Strongly Disagree. From the questionnaire, some of the included questions in the three themes were;

Attitudes towards Pastoral Counseling Scale

I. Have you ever sought pastoral counseling for your mental health problems?
II. When was the last pastoral counseling session that was mentally related?

III. Does mental illness make it difficult for you to understand redemption?

IV. Do you believe that other people can benefit from pastoral counseling for their mental problems?

Competency of Pastoral Counseling Scale

I. Following the last pastoral counseling session, do you agree there are recurrent mental issues in your life?

II. Does mental illness affect the ability to live like a Christian?

III. Has counseling with the pastor enabled you to think about life and faith as well as mental problems?

IV. Do you believe that the local churches should be involved in the counseling of mental patients?

Confidence of Congregants in Pastoral team Scale

V. Do you believe a Christian with acute mental illness can succeed spiritually even without treatment?

VI. Is pastoral counseling sessions important for the treatment of mental illnesses?

Method of Analysis

The data analysis will consist of the survey questionnaire responses to enhance clarity, coherence, and consistency. The responses will be arranged based on the themes and the frequency of each theme compared to the research questions. For easier interpretation, the frequency tables, as well as the descriptive statistics, will be constructed to display the results. The responses received from the 106 participants will be used for the analysis.
Assumptions and Limitations

This is research that involves the use of a case study based on the Deliverance Center for all Nations Church. While this may act as a representative sample of the situation in the Christian setting, mental illnesses are a complex and challenging situation to understand. Therefore, a single church cannot be used to generalize all the results, or the views of the church members cannot be used to mean that all the other denominations feel the same. Such studies assume that the pastoral communities operate the same in all churches. However, it is clear that many denominations have a theoretical basis for dealing with matters involving mental illnesses. Therefore, drawing some responses from a section of the congregation can only be used to make conclusions hypothetically.

The questionnaires used in this survey largely depend on the respondents for accuracy. However, the researcher took steps to ensure that the questions were interpreted for the participants before they provided the feedback. At the same time, the respondents were assured of the confidentiality of their responses as their participation would remain anonymous. The researcher assumed that since these were Christians, then the responses given would be accurate and truthful. The instrument then condensed the elements found in various disciplines such as psychology, sociology, and psychiatry. Pastoral counseling was presented independently since the effect they have is unknown.

The surveys were administered at Deliverance Center for all Nations Church. However, with a congregation of more than 1000 people, only 106 of them were participating. It means that it is possible that this is not a representative sample of the church; more than three quarters were absent from the survey. At the same time, the researcher is not a member of the church, and hence it is difficult to understand some issues among the congregation. In addition to the use of
the questionnaire to collect data, it is important also to consider that no one knows the amount of
time that the clergymen spend doing counseling of mental illnesses. The ministry in Deliverance
Center for all Nations Church dedicates 36 hours in a week for all counseling sessions. It is a
figure that does not give the exact time that is spent seeing the mentally ill patients. However,
what is clear is that the time is mostly spent with persons with mental health jeopardy, and hence
it shows that counseling is given a qualitative significance for mental health. Troubled people
may opt to seek help from the pastors instead of the psychologist or a social worker. As such, the
clergy are faced with a high demand situation. According to Kelly et al., 42% of the Americans
have sought help from the clergymen when they have mental problems compared to the 18%
who first turn to the psychologists.112

According to the literature review, pastors believe that it is important to combine the use
of psychological counseling with spirituality when handling mentally ill individuals. At the same
time, other people believe that mental problems need a psychologist and not spiritual knowledge.
All these will help develop a model that is effective in assisting the congregation in receiving
better care when faced with mental problems. The models developed will not be limited to the
mitigation of the metal problems but also on the prevention of the issues through analysis of the
onset symptoms. The assumption in this study is that the pastors attend pastoral training and
courses in counseling, which enable them to deal with such problems as mental illnesses. It is
thus necessary for the development of a model that shows the effectiveness of pastoral
counseling in the prevention of mental illnesses. Pastors provide care pastoral care to their

112 Erin Kelly, Lei Duan, Heather Cohen, Holly Kiger, Laura Pancake, & John Brekke, “Integrating
Behavioral Healthcare for Individuals with Serious Mental Illness: A Randomized Controlled Trial of a Peer Health
congregation, with the main aim being to ensure that they receive both physical and mental wellness. It is thus important to note that the pastors provide a holistic approach to provide balance and comfort in times of mental problems.

The role of the pastor is to ensure that the church members have a healthy and sound mind and faith. It is only possible when they provide the necessary support to the congregation. Different models are used at the churches for mental counseling. Biblical counseling was founded in 1970 by Jay Adams, who was opposed to secular psychology.\textsuperscript{113} He wanted to base everything that the Christians did on the bible. Pastoral counseling is different from biblical counseling because pastoral counseling does not have a specific approach but rather is done focusing on the spiritual life of an individual. In pastoral counseling, a pastor may or may not have the training to deal with mental health problems, but they can give guidance and advice based on the problem an individual is facing. For this reason, the extent of the effectiveness of the counseling provided at the church is not known.

In some instances, the Deliverance Center for all Nations Church hires the professional counselors to deal with mental problems. However, this is an issue that affects the trust of the people, mainly because the reason why many of them seek pastoral help is due to the confidence they have in them. Using professional psychologists is viewed as an event that brings outsiders to deal with the problems of the church. As a result, the number of people seeking these services declines. The church therapy provided for in the church is thus hybrid, which brings together the Christian counselors and the pastors. As a result, the responses received will not indicate pastoral

counseling in mental illness because there are mental health professionals also working from within the church.

The hybrid model used can be divided into the pastoral counselor model, where the pastors and the staff within the church provide mental counseling to the congregation. It is beneficial since it is free for those in need. However, the pastors, apart from in rare circumstances, are not licensed to offer these services. There is also low accountability for the patient to change. It has to be combined with the church benevolence model, where church employed psychologists offer services to the congregation.\textsuperscript{114} It is a low cost because it is free for those who need it. However, the congregation can overwhelm the psychologist with their needs. At the same time, the pastors may not understand the issue of mental depression, especially when it pertains to their members, because the first impression is a need for spiritual help. Therefore, the data obtained on whether people have ever had a mental problem may be inaccurate from a church setting. It is thus important to provide them with the right knowledge and skills so they can offer competent services to the congregation.

The National Alliance on Mental Illness states that about 40\% of the American population with mental illnesses seeks treatment.\textsuperscript{115} As such, Christians cannot rely on secular psychology for their help. The problems of unavailable services and the stigma of getting treatment for mental health is one major reason why many people, including Christians, are not


willing to seek help. Therefore, although the pastors may be dealing with higher numbers, it is only a small fraction that has come out to admit they have a mental problem and seek help. It means that this data from the research cannot be used to refer to the situation in the churches generally. In some instances, discrimination and the correlation of mental illnesses with spirituality have hindered many people from seeking help. Therefore, the church model of counseling should focus on using trained individuals to cater to the mental needs of the congregations. The complexities of mental health require a professional approach in dealing with them.

The effectiveness of the counseling services will also not be well understood due to the notion that people hold that a church is a place for spiritual and emotional healing. It is for this reason that people will not admit they have a problem when the counseling services do not yield the necessary results. People are likely to hold that the services were helpful even when they were not. As such, this study is purely dependent on the accuracy and faithfulness that the participants will give. The belief in the perfect nature of the church is likely to interfere with this. Irrespective of some churches not knowing what to do when faced with a member with mental problems, they offer the services. However, it is well agreed that church therapy should be adopted to offer services for their members and ensure they are well taken care of.

At the same time, some people in the church remain loyal to their pastors. They were faced with mental problems that might not have been resolved by the pastoral team. They may have sought the help of a professional psychologist. However, they may not admit it in this research as this may be seen as a lack of trust and belief in the church and Christianity faith. However, some people appreciate that they are able to share their mental stories and are still
appreciated in the churches. As such, they have found new methods of working with the congregation to enhance their mental health alongside their spirituality.

Trustworthiness

In this research study, there was no direct contact with the church members that would hinder the effectiveness of this study. Many of the participants in this study have a Christian background and hence understand how they consider certain matters such as mental illnesses. The results of this study conclude that some individuals may be suffering or experiencing mental health issues such as depression, anxiety, and stress; still, this study is not used to treat, diagnose, prevent, or give any medical advice. There is no knowledge of what the outcome is or whether these patients finally acquire mental wellness. However, it is important to know that people turn to the pastors for help with their mental illnesses due to the trust they have with them. They, however, do not understand the problems that can befall them, especially when the pastor has no professional background in mental health. It is also important that the spiritual leaders understand their influence and role in the society and hence strive to give the right information to these congregants who seek their help. It is because people find it easy to express their true feelings when they know nobody is monitoring or hearing them. With the church set up, it is easier for people to shy away from such methods as interviews because they do not want to be seen participating. However, this is an approach that denied the researcher the body expressions, which are valuable, especially when using interviews. They can be used to gain more information. However, thematic ideas come from the analysis of the responses given in a questionnaire. The method also requires the participants to take as much time as they need before they return the questionnaire. A less hurried setting ensures that there is accuracy, especially with personal information, while assuring them that it is not easy to link anyone to it.
The concept of trustworthiness in this research is to ensure that data obtained is accurate. It evaluates the goodness of the study. In a quantitative study, the lack of validity and reliability often delineates the quality of the research. However, qualitatively, this is not applicable because there are no numbers involves. Therefore, since this is a research that seeks to collect both qualitative and quantitative information, it is important to enhance trustworthiness to ensure the validity of the data collected. The components of trustworthiness can be considered through credibility as well as reliability and conformability of the research.

Ethical considerations

The researcher was careful to protect the identity of the participants. Prior to administering the questionnaires, each of the participants was required to sign the consent documents. They were also informed of the importance of keeping a copy so that they are able to identify their roles during the survey. The participants were also given the appropriate information on how their responses will be utilized. The collected information will only be used for the research, and upon completion, they will be destroyed. At the same time, the responses will be anonymous to prevent the incidence where an individual is identified. They were also told not to write their names on the questionnaires to maintain their anonymity.

Summary of Methodology

The purpose of the methodology section was to outline the research methods that were used in this research. It was also to explain the sample selection and the rationale used in designing, collecting, and analyzing data. To some extent, the questionnaire seeks to obtain both qualitative and quantitative information from the participants. The questions formulated were divided into themes that enabled easier interpretation and analysis of data. The methodology also examined how the information collected was useful to the researcher, especially by considering
the concept of trustworthiness. The Deliverance Center for all Nations Church was used in the study due to its size and the availability of the counseling services for the mentally ill. At the same time, the church has a well-structured approach to issues related to its members.

The methodology also included information about the participants, their sampling, and how they participated in the survey. The survey was for people who were above 18 years of age and must be members of the church. The main reason this was restricted was so as to avoid including other faiths and deal with the limitations of using different religious approaches to pastoral counseling on mental illnesses.

The methodology section also outlined how the researcher can obtain and secure the information collected from the participants. The privacy of all of the data is important, and this is the reason all information acquired was used for the research alone. It was not to be used in any way that could give away the identity of the members. The researcher promised to destroy the questionnaires once the research was over and a comprehensive report was available. The researcher obtained the participants’ consent before they were involved in the study to show that they did so voluntarily and that the information acquired was given by them.

The chapter also outlined the research design used in researching pastoral counseling on mental illnesses. The steps used included the sampling of the participants, data collection, data sample background, instrumentation, research questions and hypothesis, and the ethical considerations. The final part was a summary of the methodology section.
Chapter 4

Results

This chapter will uncover the findings obtained from the research. The primary objective of the study was to find out the effects of pastoral counseling on mental health. The researcher conducted a research survey to obtain the relevant data required to achieve the research objective. The data collection tool used in this study was a survey questionnaire that contained a total of 21 questions. The design of the questionnaire was in line with the specific objectives of this study. This chapter will present the respondents' background information and the findings from the analysis in line with the research objectives.

Data Analysis

Descriptive statistics were used in the discussion of the findings of the research. The results were explained using percentages. The target respondents of the study sampled using simple random sampling. However, the primary target sample was that of people who had experienced some form of mental health at a certain point in their lives. The primary criterion for sampling was that the individual participant must have reached 18 years and above.

Response Rate

Herein the response rate is the total number of people who completed the survey correctly and met the requirements of the researcher. With a membership of more than 1,000 people, only 106 agreed to participate in the survey. The respondents were given another questionnaire to give the reasons for not participating.

Before the survey was conducted, the respondents were taken through the details of the survey before they could give consent or decline. The reason they chose to take part in the study
was that they were members of the Deliverance Center for all Nations Church and that they were of 18 years and above.

Further, they informed the candidate for undertaking the research. Additionally, the researcher told the respondents that the objective of the study was to find out whether the church members sought pastoral counseling as a remedy for addressing mental health issues and whether pastoral counseling had a positive impact on the organization. The respondents were made aware that there was no benefit whatsoever of taking part in the research, and it was voluntary. The potential risks that the respondents would experience in the study were made known to them, which were the same risks one would encounter in their daily lives. The participants informed that the information they gave would be confidential, and no one else will access them apart from the researcher. Possible contacts were availed to the respondents in case they intended to contact a third party regarding the research.

Once the participants went through the details, they were given the option to proceed with the survey or to terminate. The results are as indicated in Table 2 below.

Table 2. The Survey Response Rate

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, please begin the survey.</td>
<td>99.06%</td>
</tr>
<tr>
<td>No, I would like to exit the survey</td>
<td>0.94%</td>
</tr>
<tr>
<td><strong>Answered</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Skipped</strong></td>
<td></td>
</tr>
</tbody>
</table>

In Table 2, out of the 106 participants, 105 of them clicked that they were ready to proceed with the survey, which indicated a 99.06% response rate. Only one of them clicked skip the survey but later proceeded to complete it, making the response rate 100%. The response rate was way above the acceptable response rate of 80% in the school of Pharmacy surveys and the 60%
response rate acceptable in general surveys. Therefore, since the response rate was within the margin of the acceptable response rate, the results obtained in this survey are reliable and relatively conclusive.

**Personal Information of the Respondents**

The researcher intended to understand the personal details of the respondents. However, the respondents were requested to provide personal information that was relevant to the objective of the study.

**Respondents Gender**

The respondents’ gender was relevant in the study in classifying the results based on gender. The survey requests the respondents to reveal their gender, and the results are as indicated in the table below.

Table 3. Gender of Respondents

<table>
<thead>
<tr>
<th>What is your gender?</th>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>84.91%</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>15.09%</td>
</tr>
<tr>
<td></td>
<td><strong>Answered</strong></td>
<td><strong>106</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Skipped</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

From the table above, all 106 respondents answered this question. 90 out of the 106 respondents were female, while 16 were male. This data was in tandem with the baseline expectations. Expectations met as females are more likely to respond than males. Many studies conducted shown that women are at a higher risk of developing mental health issues compared to men. Women are more likely to suffer from mental health issues, as they are exposed frequently to
emotional problems and extremely stressful situations. Therefore, the gender difference in the respondents was the best for reliable and conclusive results.

By using the above information plotted on a graph, the following Figure 1. given.

![Figure 1. Gender Distribution of Respondents](image)

From the graph above, the percentage of the respondents that were female was 84.91%, while the men were only 15.09%.

**Level of Education of the Respondents**

The researcher sought to find out the different categories of the respondents based on education level. Education level was a crucial statistic in this study because several types of research have indicated that there is a close correlation between education levels and mental health. Higher educational levels lead to advancement in skills and awareness, which reduces the probability of a person developing mental health issues. The results for the respondents’ levels of education are as indicated in Table 4 below.
Table 4. Respondents' Level of Education

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some high school</td>
<td>21.70%</td>
</tr>
<tr>
<td>College graduate</td>
<td>32.08%</td>
</tr>
<tr>
<td>Graduate degree or beyond</td>
<td>26.42%</td>
</tr>
<tr>
<td>Some postgraduate education</td>
<td>19.81%</td>
</tr>
<tr>
<td><strong>Answered</strong></td>
<td><strong>106</strong></td>
</tr>
<tr>
<td><strong>Skipped</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

From the table above, 34 respondents were college graduates, 28 respondents had a graduate degree, 23 of them had some high school education, and the last 21 of them had some postgraduate education. In terms of educational levels, the sample respondents were well distributed, with at least all categories of education levels represented. Figure 2 shows the plot of the education levels.

![Figure 2. Education Levels of Respondents](image-url)
From the graph 2 above, a majority of the respondents were college graduates who were 32.08% of the total respondents, 26.42% of them had a degree or beyond, 21.07% of them had some high school education. The last 19.81% had some postgraduate education.

**Ethical/Racial Background of the Respondents**

The racial background of the respondents was essential in this research. The baseline data from various studies have indicated that mental health problems, especially depression, were more prevalent on the racial minorities considered as immigrants in the United States as compared to the native Americans.\(^\text{116}\) For example, Black or African Americans comprise 13.3% of the entire US population. Nevertheless, over 16.8% of them, which translates to approximately 6.8 million persons, have been diagnosed with mental health within the past one year.\(^\text{117}\) Therefore, the racial statistic was crucial in this study. Table 5 below indicates the various races or ethnic backgrounds of the respondents.

Table 5. Racial Backgrounds of Respondents

<table>
<thead>
<tr>
<th>What is your Ethnic/Racial background?</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.</td>
<td>0.00% 0</td>
</tr>
<tr>
<td>Asian: A person having origins in any of the original people of the Far East, Southeast Asia, or the Indian Subcontinent, for example, Cambodia, China, India, Japan,</td>
<td>0.94% 1</td>
</tr>
</tbody>
</table>


Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

<table>
<thead>
<tr>
<th>Race</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black or African American: A person having origins in any of the Black racial groups of Africa.</td>
<td>84.91%</td>
<td>90</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</td>
<td>0.94%</td>
<td>1</td>
</tr>
<tr>
<td>Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race</td>
<td>4.72%</td>
<td>5</td>
</tr>
<tr>
<td>White: A person having origins in any of the original peoples of Europe, The Middle East, or North Africa</td>
<td>5.66%</td>
<td>6</td>
</tr>
<tr>
<td>N/A</td>
<td>2.83%</td>
<td>3</td>
</tr>
</tbody>
</table>

Answered 106

Skipped 0

From table 5 above, 90 of the respondents, which comprised a majority of the respondents, were of black or African American origin. Only six respondents were of white descent. Five were Hispanic or Latino 3 did not know their race or were not ready to disclose it; there was one native Hawaiian or other Pacific Islander, one Asian, and zero American Indian or Alaska Native. The data met the baseline expectations since a majority of the Black or African Americans reported mental problems at some point in their lives as exhibited by different studies and by the Mental Health America.118

From Figure 3 above, 84.91% of the total respondents were of Black or African American origin. 5.66% were whites, 4.72 were of Hispanic or Latino origin, 2.83% did not reveal their races, 0.94% were of Asian descent, another 0.94 were of Hawaiian or other Pacific Islands origin, and there was no American Indian.

Findings of the Study

The respondents were of diverse traits, including gender, education level, and from the different racial background. The three features above have been linked to mental health problems by various researchers. Therefore, the researcher intended to find out the respondents had been victims of the same issue. If yes, the researcher wanted to find out further whether they sought help from pastoral counseling.
Victims of Mental Health Issues

The researcher wanted to find out the respondents had been diagnosed with a mental health problem before. The research question used to instigate the responses was whether the respondents had struggled with any mental health problem at their level. The results obtained from this research question are as indicated in table 6.

Table 6. Respondents who have ever Experienced Mental Problems.

<table>
<thead>
<tr>
<th>Have you ever personally struggled with mental illness of any kind?</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Answer Choices</strong></td>
<td><strong>Responses</strong></td>
</tr>
<tr>
<td>Yes, and it was diagnosed</td>
<td>24.00%</td>
</tr>
<tr>
<td>Yes, but it was never diagnosed</td>
<td>24.00%</td>
</tr>
<tr>
<td>No</td>
<td>51.00%</td>
</tr>
<tr>
<td>N/A</td>
<td>1.00%</td>
</tr>
<tr>
<td><strong>Answered</strong></td>
<td><strong>100</strong></td>
</tr>
<tr>
<td><strong>Skipped</strong></td>
<td><strong>6</strong></td>
</tr>
</tbody>
</table>

From the table above, 51 respondents indicated they had never been victims of any mental-problems before; 24 respondents stated that they had experienced prior mental health issues. Still, they were not diagnosed, and 24 more respondents indicated they experienced mental health issues before, but they were never diagnosed. This question did not apply to one of the respondents. Additionally, six respondents skipped the question and did not provide their answers. In total, 48 respondents out of 106 had experienced a mental health condition before, while only 51 had not. The above information was put on a graph for visualization, see figure 4.
The results above indicate that 51% of the respondents had not experienced a mental health problem by the time the survey was being conducted. Of the 48% of them had experienced a mental health condition, half were diagnosed, and 24% were never diagnosed. The question did not apply to 1% of the respondents.

In total, the percentage of respondents who had experienced a health issue was 48%, while the percentage of the respondents who had never experienced a health issue was 51%. Translating this result into the real-world environment could mean that 48 out of 100 Americans have experienced a mental health issue. Since 84.91% of the respondents were black. Converting this value to 100, it becomes 84.94 people of Black or African American origin. When this value is multiplied by 48% (the percentage of respondents who experienced mental health issues before), it translates to 40.77. Therefore, it can be concluded that in every 85 black or African American origin, 41 of them have struggled with mental illness.

Respondents who sought help from a Psychiatrist

Once it was established that some of the respondents had experienced mental health problems at some point, the researcher went ahead to find the next cause of action that was taken
by these respondents. The researcher wanted to determine the number of respondents who visited a psychiatrist for help with their mental condition. The following table 7 shows the results.

Table 7. Respondents Who Visited a Psychiatrist for Mental Health Issues

<table>
<thead>
<tr>
<th>Have you ever seen a psychiatrist as a treatment option for your mental health concerns?</th>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>22.00%</td>
<td>22</td>
</tr>
<tr>
<td>No</td>
<td>69.00%</td>
<td>69</td>
</tr>
<tr>
<td>N/A</td>
<td>9.00%</td>
<td>9</td>
</tr>
<tr>
<td>Answered</td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Skipped</td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

From table 7 above, 69 respondents indicated that they did not seek the advice of a psychiatrist. In contrast, 22 of them stated that they sought the help of a psychiatrist regarding their mental health condition. Nine respondents indicated that this question did not apply to them, while the remaining six did not answer the question at all. The above information is represented in figure 5 below.

Figure 5. Respondents Who Visited a Psychiatrist for Mental Health Issues.
From figure 5, 69% of the respondents indicated that they did not see a psychiatrist as a treatment option for their mental health concern, 22% of the respondents stated that they saw a psychiatrist for their mental health problem. In comparison, 9% indicated that the question did not apply to them. A total of 6 respondents did not answer this question, which makes the total number of respondents on this particular question to be 100. Out of the 100 respondents, 84.91 were of Black or African American origin. Since 22% of respondents saw a psychiatrist for help with their problem, this could mean that a total of 18.68 Blacks or African Americans saw a psychiatrist for help. Therefore, it means that out of 85 Blacks or African Americans, only 19 of them saw a psychiatrist for help.

**Respondents who sought help from a psychologist**

The researcher wanted to find out the number of respondents who sought help from a psychologist regarding their mental health problems. Table 8 below represents the number of respondents who received help from a psychologist.

Table 8. Respondents who Sought Help From a Psychologist

<table>
<thead>
<tr>
<th>Have you have seen a psychologist as a treatment option for your mental health concerns?</th>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>21.00%</td>
<td>21</td>
</tr>
<tr>
<td>No</td>
<td>68.00%</td>
<td>68</td>
</tr>
<tr>
<td>N/A</td>
<td>11.00%</td>
<td>11</td>
</tr>
<tr>
<td><strong>Answered</strong></td>
<td></td>
<td><strong>100</strong></td>
</tr>
<tr>
<td><strong>Skipped</strong></td>
<td></td>
<td><strong>6</strong></td>
</tr>
</tbody>
</table>

From table 8 above, 100 respondents answered this question, while six respondents did not. The respondents who sought help from a psychologist regarding their mental health condition was 21. Respondents who did not seek the help of a psychologist were 68, while those who indicated that this question did not apply to them was 11. The information is represented in figure 6.
From figure 6, the total number of respondents was 100 since 6 of them skipped the question. The percentage of respondents who sought the help of a psychologist regarding their mental health condition was 21%. The respondents who did not seek the help of a psychologist regarding their mental health condition were 68%, while 11% of the respondents indicated that this question did not apply to them. Therefore the number of Black or African Americans who sought help from a psychologist regarding their mental health was \((11\% \times 84.91) = 9.3\). These statistics indicate that out of 85 Blacks or African Americans, only 9 of them will seek help from a psychologist regarding their mental health.

**Types of Mental Health Problems**

The researcher wanted to find out the number of respondents who had suffered from various types of mental illness. The results are as indicated in table 9 below.
Table 9. Types of Mental Disorders Suffered by Respondents

<table>
<thead>
<tr>
<th>“Have you ever been diagnosed by a medical or psychological professional with any of the following conditions?”</th>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorders</td>
<td>26.00%</td>
<td>26</td>
</tr>
<tr>
<td>Bipolar Disorder (Manic-Depressive Illness)</td>
<td>4.00%</td>
<td>4</td>
</tr>
<tr>
<td>Delusions</td>
<td>1.00%</td>
<td>1</td>
</tr>
<tr>
<td>Depression</td>
<td>28.00%</td>
<td>28</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder (OCD)</td>
<td>2.00%</td>
<td>2</td>
</tr>
<tr>
<td>Post-traumatic stress disorder (PTSD)</td>
<td>9.00%</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>2.00%</td>
<td>2</td>
</tr>
<tr>
<td>None</td>
<td>57.00%</td>
<td>57</td>
</tr>
<tr>
<td>N/A</td>
<td>4.00%</td>
<td>4</td>
</tr>
<tr>
<td>Answered</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Skipped</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

The researcher intended to find out the number of respondents who experienced different categories of mental health diseases. From the table 4.5.4 above, the total number of respondents who answered this question was 100 after six of the respondents skipped it. Of the 100 respondents, 57 indicated that they had not been diagnosed with any mental health problem by a medical or psychological professional. Twenty-eight respondents stated they are diagnosed with depression. Twenty-six of them indicated that they had been diagnosed with anxiety disorders. In comparison, nine respondents had been diagnosed with post-traumatic stress disorder PTSD. Four of them had had bipolar disorder (manic-depressive illness). Two of them had been diagnosed with obsessive-compulsive disorder (OCD), an additional two had suffered other types of mental health illnesses that were not indicated in the table; only one had suffered from delusions. In contrast, four of them suggested that this question did not apply to them. The
researcher represented this information on a graph for visualization, and the results are as indicated in figure 7 below.

From figure 7 above, the total number of respondents who answered this particular question was 100, with six of the skipping it. Out of the 100 respondents, 57% of them indicated they had not been diagnosed with any mental health problem by a medical or a psychological professional. 28% indicated that they had been diagnosed with depression, and 26% indicated that they had been diagnosed with an anxiety disorder. 9% of them had been diagnosed with post-traumatic stress disorder, 4% with bipolar disorder, while another 4% indicated that this question did not apply to them. 2% of them indicated that they had been diagnosed with obsessive-compulsive disorder. In comparison, an additional 2% had been diagnosed with other types of mental health issues apart from those mentioned above. It is only 1% of the respondents that had been diagnosed with delusions.

Figure 7. Types of Mental Disorders Suffered by Respondents.

“Have you ever been diagnosed by a medical or psychological professional with any of the following conditions?”

Responses
Respondents’ Current Status of Mental Illness

The researcher wanted to find out the current status of the mental illness of each respondent to determine whether they obtained adequate help or not. The results obtained from the respondents are as illustrated in table 10 below.

Table 10. Current Status of Mental Illness of Respondents

<table>
<thead>
<tr>
<th>“How would you describe your current status with your mental illness?”</th>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Stable</td>
<td>38.00%</td>
<td>38</td>
</tr>
<tr>
<td>Somewhat Stable</td>
<td>42.00%</td>
<td>42</td>
</tr>
<tr>
<td>Somewhat Unstable</td>
<td>8.00%</td>
<td>8</td>
</tr>
<tr>
<td>Very Unstable</td>
<td>2.00%</td>
<td>2</td>
</tr>
<tr>
<td>N/A</td>
<td>10.00%</td>
<td>10</td>
</tr>
<tr>
<td>Answered</td>
<td><strong>100</strong></td>
<td></td>
</tr>
<tr>
<td>Skipped</td>
<td></td>
<td><strong>6</strong></td>
</tr>
</tbody>
</table>

In the table above the total number, the total number of respondents who answered the question were 100 since six of them skipped it. Forty-two of them indicated that their current status of mental illness was somewhat stable. Thirty-eight indicated that they were very stable; ten respondents indicated that this question did not apply to them; eight respondents indicated that they were somewhat unstable. Two indicated that they were very stable. For better visualization, the researcher plotted the above information on a graph, and the results are as indicated in figure 8 below.
From figure 8 above, 42% of the respondents indicated that the current condition of their mental illness was somewhat stable, 38% stated that they were very stable, 10% of them indicated that this question did not apply to them, 8% indicated that they were somewhat unstable. The remaining 2% indicated that their current status of mental illness is very stable.

**Acute Mental Illness and Ability to Understand Redemption**

The researcher intended to find out whether acute mental illness hindered the respondents from understanding redemption. The results of these questions are as indicated in table 11 below.
Table 11. Acute Mental Illness Impact on Respondents' Ability to Understand Redemption

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>5.00%%</td>
</tr>
<tr>
<td>Agree</td>
<td>10.00%%</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>20.00%%</td>
</tr>
<tr>
<td>Disagree</td>
<td>16.00%%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>20.00%%</td>
</tr>
<tr>
<td>N/A</td>
<td>29.00%%</td>
</tr>
<tr>
<td><strong>Answered</strong></td>
<td><strong>100</strong></td>
</tr>
<tr>
<td><strong>Skipped</strong></td>
<td><strong>6</strong></td>
</tr>
</tbody>
</table>

In table 11 above, the total number of respondents who answered this question was 100 since six of them skipped it. From the 100 respondents, 29 indicated that this question did not apply to them; 20 respondents said they strongly disagree, meaning that their acute mental illness did not make it difficult for them to understand redemption. Another 20 respondents said that they neither agree nor disagree. Sixteen respondents disagreed, indicating that their acute mental illness did not hinder their comprehension of redemption. A total of 10 respondents agreed to say that their acute mental illness made it difficult for them to understand redemption. In comparison, ten respondents strongly agreed that their acute mental illness made it difficult for them to understand redemption. The total number of respondents who claimed that their acute mental illness made it difficult for them to understand redemption was 15. The above information was plotted in figure 10 below.
Figure 9. Acute Mental Illness Impact on Respondents' Ability to Understand Redemption

From figure 10 above, 29% of the respondents indicated that the question did not apply to them; 20% of them strongly disagree; another 20% indicated that they neither agree nor disagree; 16% of the respondents disagree; 10% agreed to indicate that acute mental illness made it difficult for them to understand redemption while 5% strongly agreed. The total percentage of the respondents who agreed that acute mental illness made it difficult for them to understand redemption was 15%, which was a significant percentage.

**Acute Mental Illness and Christian Spiritual Success**

The researcher wanted to find out whether the respondents believed that Christine, with an acute mental illness, was able to succeed even if the illness was not treated. The results of the respondents are as indicated in table 12 below.
Table 12. Acute Mental Illness need NOT be treated for Christian Spiritual Success?

“I believe a Christian with an acute mental illness can succeed spiritually even if the illness has not been treated.”

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>14.00%</td>
</tr>
<tr>
<td>Agree</td>
<td>18.00%</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>23.00%</td>
</tr>
<tr>
<td>Disagree</td>
<td>25.00%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>10.00%</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>10.00%</td>
</tr>
</tbody>
</table>

Answered 100

Skipped 6

From table 12 above, the total number of respondents was 100 after six respondents skipped the question. Of the 100 respondents, 25 of them disagreed, 23 of them neither agreed nor disagreed, 18 of them agreed, 14 strongly agreed, 10 of them strongly disagreed, another ten respondents were not aware. The total number of respondents who agreed that Christians with an acute mental disability could succeed spiritually even if the illness had not been treated was 32, while those who disagreed were 35. When the above information was represented on a graph, the results were indicated in figure 11 below.
Figure 10. Acute Mental Illness need NOT be treated for Christian Spiritual Success.

From the table above, 25% of the respondents disagreed, 23% of them neither agreed nor disagreed, while 18% agree, some 4% of the respondents strongly agreed, while 10% of them strongly disagreed while the last 10% were not aware. Therefore, the total percentage of the respondents that agreed that a Christian with an acute mental illness could succeed spiritually even if the disease has not been treated was 32%. In comparison, those who disagreed were 35%. Hence, a majority of the respondents disagreed with this statement, which could infer little faith or absence of adequate evidence to back up the account.

Whether acute mental illness weakened the respondents’ efforts to live like a Christian

The researcher intended to find out whether acute mental illness undermines one's efforts to live as a Christian. The researcher posed this question to the respondents, and the results obtained are as indicated in table 13 below.
Table 13 Acute Mental Illness WEAKENS One's Efforts to Live like a Christian?

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>6.00%</td>
</tr>
<tr>
<td>Agree</td>
<td>8.00%</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>15.00%</td>
</tr>
<tr>
<td>Disagree</td>
<td>26.00%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>17.00%</td>
</tr>
<tr>
<td>N/A</td>
<td>28.00%</td>
</tr>
<tr>
<td><strong>Answered</strong></td>
<td><strong>100</strong></td>
</tr>
<tr>
<td><strong>Skipped</strong></td>
<td></td>
</tr>
</tbody>
</table>

In table 13 above, the total number of respondents was 100 since 6 of them skipped the question. When the respondents were asked whether they think that one’s acute mental illness weakened their efforts to live like a Christian, 28 respondents indicated that the question did not apply to them. The number of respondents who disagreed was 26, while 17 strongly disagreed. Those who neither agreed nor disagreed was 15. Those who agreed numbered eight, while those who strongly agreed were 6. The total number of respondents who agreed was 14, while those who disagreed was 43. Therefore, most of the respondents disagreed that their acute mental illness weakened their efforts to live like Christians.

**Respondents who Sought Pastoral Counselling as a Treatment Option for Mental Health Concerns.**

The researcher wanted to find out how many respondents had ever sought pastoral counseling as a treatment option for their mental health problems. The results are as indicated in table 14 below.
Table 14. Respondents who Sought Pastoral Counseling for their Mental Health Concerns

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>15.05%</td>
</tr>
<tr>
<td>No</td>
<td>84.95%</td>
</tr>
<tr>
<td>Answered</td>
<td></td>
</tr>
<tr>
<td>Skipped</td>
<td></td>
</tr>
</tbody>
</table>

In table 14 above, the total number of respondents who answered the question was 93, while 13 respondents skipped it. Thirteen respondents indicated yes they had sought pastoral advice as a treatment option for their mental health concerns, while 79 of them said no. Fourteen was a significant number of respondents, even though it was still small. When the results were plotted on a graph, figure 12 below was obtained.

Figure 11. Respondents who Sought Pastoral Counseling for their Mental Health Concerns.

In the table above, 84.95% of the respondents did not seek pastoral counseling, while 15.05% of the respondents sought pastoral counseling. The results indicate that a majority of the
respondents did not seek pastoral counseling for whatsoever reason. However, 15.05 was a significant percentage with the potential to grow.

**Respondent’s Pastoral Last Counselling Session**

The researcher wanted to find out when the last pastoral counseling session that the respondent had occurred. The results are as indicated in table 15 below.

Table 15. Last Pastoral Counseling Session

<table>
<thead>
<tr>
<th>If so, when was the last counseling session?</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answer Choices</td>
<td>Responses</td>
</tr>
<tr>
<td>One month or less</td>
<td>3.23%</td>
</tr>
<tr>
<td>Two to six months ago</td>
<td>2.15%</td>
</tr>
<tr>
<td>Six to Twelve months ago</td>
<td>3.23%</td>
</tr>
<tr>
<td>More than a year ago</td>
<td>7.53%</td>
</tr>
<tr>
<td>N/A</td>
<td>83.87%</td>
</tr>
<tr>
<td><strong>Answered</strong></td>
<td><strong>93</strong></td>
</tr>
<tr>
<td><strong>Skipped</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

In the table above, the respondents were required to indicate the last time they had a pastoral counseling session to treat their mental illness. In the table, 13 respondents skipped the question while 93 of them answered. Seventy-eight of the respondents indicated that the question did not apply to them. Seven respondents indicated that the last pastoral session they had was over one year back. Three respondents indicated that it was six to twelve months ago, while an additional three indicated that one month or less, and the final two respondents indicated that it was two to six months ago. When the above data was plotted on a graph for representing the results are as indicated in figure 13 below.
From figure 13 above, the highest percentage, 83.87% of respondents, indicated that this question did not apply to them. 7.53% of the respondents stated that it was over one year ago, 3.23% of them indicated that it was six to twelve months ago, while an additional 3.23% stated that it was one month or less. The last 2.15% of the respondents indicated that it was two to six months ago.

**Respondents Views on the Pastoral Counselling on their Mental illness**

The researcher wanted to find out whether the respondents agreed that pastoral counseling sessions were beneficial to the respondents’ treatment plan. The results obtained from the questionnaire are as indicated in table 16 below.
Table 16. Were Pastoral Counseling Sessions Beneficial?

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>12.90%</td>
<td>12</td>
</tr>
<tr>
<td>Agree</td>
<td>20.43%</td>
<td>19</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>16.13%</td>
<td>15</td>
</tr>
<tr>
<td>Disagree</td>
<td>6.45%</td>
<td>6</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>1.08%</td>
<td>1</td>
</tr>
<tr>
<td>N/A</td>
<td>43.01%</td>
<td>40</td>
</tr>
</tbody>
</table>

Answered 93  
Skipped 13

In the table above, the total number of respondents was 93 after 13 respondents decided to skip the question. Forty respondents indicated that the question did not apply to them. Nineteen respondents agreed, while 12 respondents strongly agreed. Fifteen respondents neither agreed nor disagreed. Six respondents disagreed, while one respondent strongly disagreed. The total number of respondents who agreed that pastoral counseling sessions were beneficial to their treatment plans was 31, while those who disagreed were only 7. Therefore, many respondents believe that pastoral counseling was beneficial, and this was promising. The above information was plotted on a graph for visualization; the results were indicated in figure 14 below.
Figure 13. Were Pastoral Counseling Sessions Beneficial?

From the figure above, 43.01% of the respondents indicated that the question did not apply to them. 1.08% of them strongly disagreed, and 6.45% of the respondents disagreed. In comparison, 16.13% of the respondents neither agreed nor disagreed. Further, 20.43% of the respondents agreed, while 12.90% of the respondents strongly agreed. The total percentage of the respondents who agreed that pastoral counseling sessions were beneficial in their treatment plan was 33.33%, while those who disagreed was 7.53%. Therefore, a good percentage of the respondents agreed, indicating that pastoral counseling sessions were beneficial.

Pastoral Counselling and Recurrent Struggles in Mental Illness

The researcher wanted to find out whether the respondents underwent recurrent struggles with their mental illness after a pastoral counseling session. The results are as indicated in table 17 below.
Table 17. Recurrent Struggles with Mental Illness after a Pastoral Counseling Session?

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>3.23%</td>
</tr>
<tr>
<td>Agree</td>
<td>7.53%</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>15.05%</td>
</tr>
<tr>
<td>Disagree</td>
<td>3.23%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>5.38%</td>
</tr>
<tr>
<td>N/A</td>
<td>65.59%</td>
</tr>
</tbody>
</table>

Answered 93

Skipped 13

From the table above, 61 respondents said that the question did not apply to them. Five respondents strongly disagreed, three disagreed, 14 neither agreed nor disagreed, seven respondents agreed while 3 of them strongly agreed. The total number of respondents who agreed was ten, while those who disagreed were 8. See figure 15 in graph form.

Figure 14. Recurrent Struggles with Mental Illness after a Pastoral Counseling Session?
In figure 15 above, 65.59% of the respondents indicated that the question did not apply to them. 5.38% of the respondents strongly disagreed, 3.23% of them disagreed, while 15.05% of them neither agreed nor disagreed. Further, 7.53% of the respondents agreed, while 3.23% strongly agreed. The total percentage of respondents who agreed was 10.76%, while those who disagreed was 8.61%.

**Pastoral Counselling and improvement of the symptoms of mental health**

The researcher wanted to find out whether the symptoms of mental illness of the respondents improved after their last pastoral counseling, and the results are as indicated in table 18 below.

Table 18. Improvement of Mental Health Impairment after Pastoral Counseling Session?

<table>
<thead>
<tr>
<th>Have the symptoms of your mental health impairment improved since your last pastoral counseling session?</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>2.15%</td>
</tr>
<tr>
<td>Agree</td>
<td>6.45%</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>8.60%</td>
</tr>
<tr>
<td>Disagree</td>
<td>5.38%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>3.23%</td>
</tr>
<tr>
<td>N/A</td>
<td>74.19%</td>
</tr>
<tr>
<td>Answered</td>
<td>93</td>
</tr>
<tr>
<td>Skipped</td>
<td>13</td>
</tr>
</tbody>
</table>

In table 18 above, 13 respondents skipped the question, while 69 of them indicated that the question did not apply to them. Three strongly disagreed, five respondents agreed, while eight respondents neither agreed nor disagreed. Further, six respondents agreed, while two respondents strongly agreed. The total number of respondents who agreed that their symptoms of mental health impairment improved after their last pastoral counseling session was 8, while those who
disagreed were also 8. When this information is plotted on a graph, the results are as indicated in figure 16 below.

Figure 15. Improvement of Mental Health Impairment after Pastoral Counseling Session?

In the figure above, the total percentage of employees who indicated that the question did not apply to them was 74.19%. 3.23% of the respondents strongly disagreed, 5.38% disagreed, while 8.60% neither agreed nor disagreed. Further, 6.45% of the respondents agreed, while 2.15% of the respondents strongly agreed. The total percentage of the respondents who agreed was that the symptoms of their mental impairment improved after their last pastoral counseling session was 8.60%, while those that disagreed was 8.60%.

Respondent's views on whether others will benefit from pastoral counseling as a treatment option for mental illness.

The researcher wanted to get the respondents' opinions on whether they agreed that other people would benefit from pastoral counseling as a treatment to their mental health. The results are as indicated in table 19 below.
Table 19. Would Others Benefit from Pastoral Counseling Session Mental Illness?

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>18.28%</td>
</tr>
<tr>
<td>Agree</td>
<td>31.18%</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>36.56%</td>
</tr>
<tr>
<td>Disagree</td>
<td>8.60%</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>5.38%</td>
</tr>
<tr>
<td><strong>Answered</strong></td>
<td><strong>93</strong></td>
</tr>
<tr>
<td><strong>Skipped</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

In table 19 above, the number of respondents who skipped the question was 13. 5 respondents strongly disagreed, eight respondents disagreed, while 34 respondents neither agreed nor disagreed. Further, 29 respondents agreed, while 17 respondents strongly agreed. The total number of respondents who agreed that other people would benefit from the pastoral counseling sessions as a treatment to their mental illness was 46, while those who disagreed were 13. Therefore, it was clear that pastoral counseling was of benefit. When these results were represented on a graph, the following figure 17 was obtained.
In Figure 17 above, the percentage of respondents who strongly disagreed was 5.38%, 8.60% disagreed, while 36.56% neither agreed nor disagreed. Further, the percentage of respondents who agreed was 31.18%, while those who strongly agreed was 18.28%. The total percentage of respondents who agreed that other people would benefit from the pastoral counseling sessions if they include it as an option of treatment for their mental illness was 49.46%. In comparison, those who disagreed was 13.98%.

**Respondents views on the local church regarding mental illness**

The researcher wanted to find out the respondents' views on the local church regarding mental illness. The results are as indicated in Table 20 below.
Table 20. Respondents’ Views of Local Church as Mental Illness is Concerned

<table>
<thead>
<tr>
<th>“As I have dealt with mental illness, I have found the local church to be”</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly Supportive</td>
<td>10.75%</td>
</tr>
<tr>
<td>Somewhat Supportive</td>
<td>17.20%</td>
</tr>
<tr>
<td>Neither Supportive nor Unsupportive</td>
<td>7.53%</td>
</tr>
<tr>
<td>Somewhat Unsupportive</td>
<td>4.30%</td>
</tr>
<tr>
<td>Mostly Unsupportive</td>
<td>2.15%</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>15.05%</td>
</tr>
<tr>
<td>N/A</td>
<td>43.01%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly Supportive</td>
<td>10</td>
</tr>
<tr>
<td>Somewhat Supportive</td>
<td>16</td>
</tr>
<tr>
<td>Neither Supportive nor Unsupportive</td>
<td>7</td>
</tr>
<tr>
<td>Somewhat Unsupportive</td>
<td>4</td>
</tr>
<tr>
<td>Mostly Unsupportive</td>
<td>2</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>14</td>
</tr>
<tr>
<td>N/A</td>
<td>40</td>
</tr>
</tbody>
</table>

Answered 93
Skipped 13

In table 20 above, the total number of respondents who skipped the question was 13, while 40 respondents indicated that the question did not apply to them. Fourteen respondents indicated that they were not aware of it. Two respondents indicated that the church was mostly unsupportive. While four indicated that the local church was somewhat unsupportive. A total of 7 respondents indicated that the local church was neither supportive nor unsupportive; 16 respondents indicated that the local church was somewhat supportive, and the final ten respondents indicated that the local church was mostly supportive. A total of 26 respondents indicated that the church was supportive in as far as mental illness was concerned, while 6 respondents indicated that the local church was unsupportive. When the above data was plotted on a graph for ease of visualization, figure 18 below was obtained.
In figure 18 above, 43.01% of the respondents indicated that the question did not apply to them. 15.05% stated that they were not aware of it. 2.15% of the respondents indicated that the church was mostly unsupportive. 4.30 indicated that it was somewhat unsupportive. 7.53% of the respondents indicated that the church was neither supportive nor unsupportive. Further, 17.20% of the respondents indicated that the church was somewhat supportive, while 10.75% of the respondents indicated that the church was mostly supportive. The total percentage of the respondents who indicated that the church was supportive in combating mental illness was 27.95%. In comparison, 6.45% of the respondents believed that the local church was unsupportive in as far as mental illness is concerned.

**Whether Pastoral Counselling helped the Respondents think through and leave out their faith in mental illness context.**

The researcher intended to find out whether pastoral counseling sessions have helped the respondents live out their faith in the context of mental illness. The results obtained are as recorded in table 21 below.
Table 21. Pastoral Counseling Sessions helped Respondents Live out Faith in Mental Illness

Context

<table>
<thead>
<tr>
<th>Counseling sessions with my pastor has explicitly helped me think through and live out my faith in the context of my mental illness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answer Choices</td>
</tr>
<tr>
<td>Strongly agree</td>
</tr>
<tr>
<td>Agree</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
</tr>
<tr>
<td>Disagree</td>
</tr>
<tr>
<td>Strongly disagree</td>
</tr>
<tr>
<td>Don’t Know</td>
</tr>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

Answered 93
Skipped 13

In table 21 above, a total of 13 respondents skipped the question. Fifty-nine respondents indicated that the issue did not apply to them. Seven respondents indicated that they did not know while none of them strongly disagreed. Only one respondent disagreed, and 11 neither agreed nor disagreed. Further, seven respondents agreed, while eight strongly agreed. The total number of respondents who agreed that pastoral counseling sessions helped them live out their faith in as far as mental illness was concerned was 15 respondents, while only one respondent disagreed. When the results were plotted on a graph for visualization, figure 19 below was obtained.
In figure 19 above, 63.44% of the total respondents indicated that this question did not apply to them, 7.53% said they did not know, while none of the respondents strongly disagreed. 1.08% of the respondents disagreed, while 11.83% of the respondents neither agreed nor disagreed. Further, 7.53% of the respondents agreed, while 8.60% of the respondents strongly agreed. The total percentage of respondents who agreed that the pastoral counseling sessions helped them live out their faith in as far as mental illness is concerned was 16.13%, while those who disagreed was only 1.08%.
Respondents perception of the areas where local churches assist people with acute mental illnesses

The researcher wanted to find out whether the local church helped people with critical mental illness in any way. The results obtained are as indicated in table 22 below.

Table 22. Areas for Local Church to Assist People with Mental Illness

| Free Response: May select multiple answers: Do you believe local churches should assist individuals with acute mental illness in any of the following areas?” | Answer Choices                                                                 | Responses |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|
| Help families find local resources for support and dealing with the illness                                                                                 | 78.49%    | 73        |
| Talk about it openly so that the topic is not so taboo                                                                                                      | 72.04%    | 67        |
| Improve people's understanding of what mental illness is and what to expect                                                                               | 69.89%    | 65        |
| Increase awareness of how prevalent mental illness is today                                                                                                 | 68.82%    | 64        |
| Provide training for the church to understand mental illness                                                                                            | 65.59%    | 61        |
| Offer topical seminars on depression or anxiety                                                                                                            | 58.06%    | 54        |
| Have a counselor on staff skilled in mental illness                                                                                                      | 66.67%    | 62        |
| Don't know                                                                                                                                                    | 7.53%     | 7         |
| Other (please specify)                                                                                                                                         |           | 1         |

Answered 93
Skipped 13

In table 22 above, the number of respondents who skipped this question was 13, while seven more respondents indicated that they did not know. One respondent indicated others but did not specify. Sixty-two respondents indicated that the local church should have a counselor on staff who is skilled in mental illness, which translated to 66.67% of the respondents. Fifty-four respondents, who are 58.06% of the total respondents, indicated that the local church should offer seminars with topics on anxiety and depression. Sixty-one respondents, who are 65.59% of
the total respondents, stated that the local church should provide pieces of training to the
congregation on mental illness. Sixty-four respondents, which translates to 68.82% of the
respondents, stated that the church should increase awareness of the prevalence of mental illness.
Sixty-five respondents, which translates to 69.89% of the respondents, indicated that the local
church should help people understand mental illness and what they should expect. Sixty-seven
respondents, which translates to 72.04% of the total respondents, indicated that the church should
talk about mental illness openly. The final 73 respondents, which indicates 78.49% of all the
respondents, indicated that the church should help families obtain resources to deal with mental
illness. Figure 20 below helps in the visualization of the above information.

Figure 19. Areas for Local Church to Assist People with Mental Illness
Pastoral Counseling on mental health has a tremendous impact on contemporary culture. Pastoral Counseling expresses a vital role in effectively addressing the problems of individuals in vulnerable situations. At the same time, it emphasizes that the value of spirituality comes from it as an aspect of the human way of being in the universe. In this respect, it is essential to stress the strategies to existential Counseling, which underlines the reality that the human horizon combines the physical, financial, personal, and spiritual aspects. Besides how one interprets faith, philosophy, and spirituality, one can note that there is a significant difference between religion and spirituality, even if one embraces a broader sense of spirituality that also contains a religious element.

The contemporary world leaves room for religion and spirituality in a broad range of situations, from the incorporation of the concepts of bioethics to public health initiatives and meaningful measures in the lives of people.\(^\text{119}\) The presence of religious or spiritual elements involves a firm commitment to the principles of the person and, in particular, to the principles which work for the good of the client subject to a therapeutic approach.\(^\text{120}\)


\(^\text{120}\) Ibid.
Supporting the Hypothesis

The results of this study justify that the alternate hypothesis can be adopted and the conclusion drawn that is there is no correlation between the subject’s mental health outcome and the pastoral counseling session received. To the survey question: “Do you agree that pastoral counseling sessions are beneficial in your treatment plan,” 33% of the population combined either agreed or strongly agreed, while 59% of the population responded “neither agree/disagree” or “Not applicable.” This represents a lower response rate to this particular group of subjects.

The survey question, “Have the symptoms of your mental health impairment improved since your last pastoral counseling session?” a combined 8% either “agreed” or “strongly agreed,” in contrast to 74% who selected “non-applicable.” This question weighs heavily in determining the null hypothesis (H₀) cannot be supported.

The survey question “As I have dealt with mental illness, I have found the local church to be” supports the conclusion that this population may all not have sought after pastoral counseling as a treatment option as 43% of the population stated N/A while 42 % stated a distribution range between unsupportive and supportive. An inference can be made that 42% of the sample population has a mental illness. This particular question definitely reduced the research bias given that some participants did not want to admit they had a mental illness, which is evident in the graphs.

The final question was about how the local church could help with mental health issues in society. The respondents gave different viewpoints, such as helping families find resources to address mental health problems, raising awareness about mental health problems so that offenders are not stigmatized, and having professional therapy on mental health issues. For
future research, hopefully, a more direct positive response to pastoral treatment is seen given a broad sample population. Regardless of the reach, though, the total collection of findings takes into account informatively, and researcher bias may still be prevalent.

Again, this congregation is predominately African American, a conclusion is made based on previous supporting evidence, and the results of this study show that African Americans are less likely to report that they have a mental illness.121 This study also added to prior research that African Americans use more religious coping strategies.122 This study also added to prior research that African Americans use more religious coping strategies. Many mental health questions did not apply to African American populations. Previous studies indicate that approximately 80% of African Americans believe religion is essential compared to 56% of the general US adult population.123

African Americans report more frequent church participation and attendance. Studies show that the collaboration between mental health professionals and clergy continues to be moderate.124 It is believed that due to the participation of clergy in counseling, mental health professionals could benefit if their associations included clergy and other community religious professionals. However, many researchers have found that there is a lack of collaboration between mental health professionals and clergy.125

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122 Ibid.
123 Thomas, “The Interprofessional Collaborative Practice,” 100.
124 Diala et al., "Racial Differences in Attitudes,” 455.
125 Thomas, “The Interprofessional Collaborative Practice,” 100.
Future Research Recommendations

This research study displays that Pastoral Counseling can be used as one of the methods of talk therapy as a treatment option for mental health; however, there is no statistical evidence within this study proving a positive correlation between the subject mental health outcome and the pastoral counseling session received. Given the population sample of this church being predominantly African American, however, they are willing to attend mental health counseling sessions with a pastor; still, future research is required to further understand if pastoral counseling will drastically improve the mental health crisis that the world faces today.

For future research, this research area will prosper from a qualitative structure. It will be valuable to examine the prevalent dynamics in the connection between mental health professionals and clergy. As previous research has shown, the integrated collaboration between ministers and experts in mental health is needed. 126 Also noted in prior studies, pastors are frontline for mental health care.

In previous research studies, clergy admitted that there is a lack of expertise and practice as mental health advocates or consultants and a lack of time or the facilities. 127 The research findings will help identify the value of professional pastoral counselors collaborating with mental health care professionals. 128 If research is consistently carried out, both time and effort, other themes such as integrationist will be revisited. The mid-century American evangelists, who sympathized more with academic research and practice, developed training programs and

126 Thomas, “The Interprofessional Collaborative Practice,” 100.
127 Ibid., 110
128 Ibid.
organizations because of their commitment to integrating traditional psychology with Christian theology, sometimes referred to as the integrationist.\textsuperscript{129}

Over time, this involvement put the integrationist trend closer to clinical psychology than its pastoral care and counseling counterpart practice as marriage and family therapists. \textsuperscript{130}In theological Counseling, integrationists are not the only solution of American evangelical Christianity to modern psychology and psychiatry.\textsuperscript{131} Romans 12:1-2 reads, “I beseech you therefore, brethren, by the mercies of God, that ye present your bodies a living sacrifice, holy, acceptable unto God, which is your reasonable service. And be not conformed to this world: but be ye transformed by the renewing of your mind, that ye may prove what that is good, and acceptable, and perfect, will of God.” Through time, this presence took the integrationist movement closer to clinical psychology than to its equivalent of pastoral care and counseling.\textsuperscript{132} Further research can add to internationalism in faith-based care settings and how the responsiveness to treatment would be if non-believers of Christ would respond to pastoral counseling integrating the clinical psychology approach.\textsuperscript{133}

In theological counseling, integrationists are not the only solution of American evangelical Christianity to modern psychology and psychiatry. The need for a working partnership between clergy and practitioners in mental health has undoubtedly been established


\textsuperscript{130} Ibid.


\textsuperscript{132} Ibid.

\textsuperscript{133} Ibid.
in past research.\textsuperscript{134} It is reported that clergymen have provided pastors as marriage and family therapists in private practice with a similar amount of counseling service.\textsuperscript{135} In previous writings on the research, clergy recognized the absence of skills and training as advisers and the lack of time for the service.\textsuperscript{136} Research explains the importance of interprofessional communication among clergy with specialists in mental health.\textsuperscript{137}

Further research studies can help pastors identify the steps that should be taken for developing or building a strong partnership with church members in regard to mental health. For example, steps could be taken to enhance the knowledge and referrals for mental health treatment in their ministries and ministry organizations. They could also allow physicians the opportunity to join their ministerial workers in providing general guidance to those seeking advice.

Pastoral counseling is closely connected to the tradition of interprofessional collaboration between clergy and mental health professionals as a consequence of this research.\textsuperscript{138} Clergy individuals would benefit from exploring opportunities to improve their mental health knowledge and awareness by participating in additional training.\textsuperscript{139} This planning could be provided through the participation or formation of mental health groups at the local or national scale.


\textsuperscript{135} Jackson, “Licensed Professional Counselors’ Perceptions,” 98.

\textsuperscript{136} Thomas, “The Interprofessional Collaborative Practice,” 110.

\textsuperscript{137} Ibid., 101.

\textsuperscript{138} Ibid.

\textsuperscript{139} Ibid.
Participation in these training programs will enhance interprofessional education for the clergy, increase the social network with professional mental health, and ultimately build a comprehensive pattern of information sharing between these two necessary professionals. The conclusion from this research analysis was that church leaders could boost their acquaintances and interprofessional education in interprofessional collaborative practice to strengthen their trust in mental health professionals as well as their teamwork and interpersonal skills.

Building better rapport and relationships can help people with M.H. and S.A. issues get the care they need in a relationship that respects their faith and provides adequate treatment. Data from this research study indicates that people from churches with a positive approach to mental health services, especially in minority communities, are in a better position to get help, so when a rapport is built, it can create a better relationship, especially in the minority communities. Cooperation with the clergy is one way of removing the structural obstacles to mental health services and that the possibility of culturally competent services.

In a collaborative relationship between mental health professionals and clergymen, it would be useful to explore if the approach helps patients with mental health disorders, while the church members can provide assistance in natural environments and different stages during the therapy process, hopefully ridding the cultural stigma towards M.H. and S.A. Luke 5:31-33 reads, “And Jesus answering said unto them, They that are whole need not a physician; but they that are sick. I came not to call the righteous, but sinners to repentance. And they said unto him, Why do the disciples of John fast often, and make prayers, and likewise the disciples of the Pharisees; but thine eat and drink?”
For additional studies, several other key areas can expand on the limitations of this study. Larger surveys will encourage the findings of this study to be replicated and the potential gender differences on responses to be investigated. In essence, although the investigator found gender differences in the control method, the sample size prevented gender-specific analyzes. For further studies of large samples, multiracial churches and the gender divisions should be examined on a broader scale. This research study represents a small steppingstone on a journey uncovering data in this research field. There is far more research to be done in this area involving mental health professionals, congregations, and ministers.

Pastors can recognize behavioral or emotional changes within their congregation from which they are leading since Pastoral Counseling gives pastors the skills necessary to do so. Pastors should assist in a mental health crisis via religious communion with God and pastorship. Ministers could also recognize signs of psychological problems with religious influences in the same manner as religious delusions. Additional research is required to assess the expectations and roles of people, advisors, and ministry that cohesively relate to psychotherapy therapy. Work compares pastoral and psychotherapeutic counseling; furthermore, it is essential to provide further clarity and research studies to show pastoral counseling's effectiveness.

The role of the Church in caring for community members with acute mental illness is crucial as statistics show that people with illnesses continue to rise. The church was in the lead in helping people with mental illness one way or the other. It is a social structure that preaches ethics, moral values, and makes the whole congregation a better place for society to live. The study was, therefore, interested in finding out whether this church in this research survey agreed with these principles by which the subjects answered the survey and if the church helped them in coping with their mental health problems.
There is a wide range of areas within the mental health space that can be focused on for additional research. Future research can investigate the level of effectiveness of pastoral counseling to substance abuse as well as the experience level of pastors being equipped to handle individuals suffering from substance abuse. Alcoholism and opioid abuse are other topics that can be evaluated with the collaboration efforts of pastoral counseling. Professional counselors and pastors can be called to deal with the situations that exacerbate alcohol abuse, such as death, illness, and disability. In the mental health space, medications are administered to patients as well, which can also be a factor in future studies.

“Flaskerud pointed to psychopharmacology as a culturally inclusive treatment method in 1986, suggesting that medications were essential to certain ethnic minority groups, including African, Hispanic, and Asian populations.”140 The findings of this study do not support the hypothesis surrounding Flaskerud. There are no differences in racial groups in the use of psychiatric services, medical services, prescription medications, or over-the-counter medicines. Nevertheless, according to one of Flaskerud’s findings, which is related to this study, a non-clinical population may have indicated fewer medicinal drugs use. This study did not examine the effects of particular medications in collaboration with pastoral counseling, however, they can be investigated to determine the level of effectiveness that the medication has on the outcome. Regardless, the word of God reads in Mathew 4:4, “But he answered and said, It is written, Man shall not live by bread alone, but by every word that proceedeth out of the mouth of God.”

This study seeks to bridge the gap between pastoral counseling and mental health; nevertheless, much work is still needed to close that gap.

http://link.galegroup.com.ezproxy.liberty.edu/apps/doc/A411334409/AONE?


Proeschold-Bell, Rae Jean, Sara Legrand, John James, Amanda Wallace, Christopher Adams, and David Toole. “A Theoretical Model of the Holistic Health of United Methodist


Appendix A

Survey

Survey Question 1: Overview and Informed Consent

Question 1 includes brief details on the survey and informed consent acknowledgment. A “filter” response is used to confirm that the individual agrees with the informed consent material in the study; participants had to answer Question 1 agreeably before continuing with the survey; Question 1 text is given below:

You are invited to be in a research study on the correlation of pastoral counseling and mental health. You were selected as a possible participant because you are 18 years of age or older and a member of Deliverance Center for all Nations church. Please read this form and ask any questions you may have before agreeing to be in the study. Cynthia Taylor, a doctoral candidate in the School of Divinity at Liberty University, is conducting this study.

BACKGROUND INFORMATION: The purpose of this study is to determine if data suggests that members of the church are actively seeking pastoral counseling as an option to address current mental health issues, and if current pastoral counseling has impacted the congregation positively.

PROCEDURES: If you agree to be in this study, I would ask you to do the following things:
Answer the survey questions provided to the best of your ability.

RISKS: The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life. Benefits: Participants should not expect to receive a direct benefit from taking part in this study.

COMPENSATION: Participants will not be compensated for participating in this study. Confidentiality: Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.

Voluntary Nature of the Study: Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time prior to submitting the survey, without affecting those relationships. How to Withdraw from the Study: If you choose to withdraw from the study, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study. Contacts and Questions: The researcher conducting this study is Cynthia Taylor. You may ask any questions you have now. If you have questions later, you are encouraged to contact her at cetaylor8@liberty.edu. You may also contact faculty chair, Dr. Garcia, at mgarcia3@liberty.edu. If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, you are
encouraged to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

1. Do you agree to these terms?
   - Yes, please begin the survey.
   - No, I would like to exit the survey (select the "Exit" button at the top right).

Involving a confirmatory response to Question 1 confirmed the participants were informed of the nature and purpose of the survey, as well as providing an agreement to voluntary participation and agreement to other elements (e.g., risk) of the survey.

Four Demographic Questions, Annotated

The four demographic questions, listed below with the accompanying chosen controlled responses, established particular differences (e.g., gender, ethnic background, education). While not crucial to all aspects of this report, this population data could be used if the results of the survey were used in succeeding research. Each demographic question contains insightful or clarifying interpretations:

2. What is your gender?
   - Female
   - Male

3. What is your highest level of education?
   - Some high school
   - College graduate
   - Graduate degree or beyond
   - Some post-graduate education

4. What is your Ethnic/Racial background?
   - American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains a tribal affiliation or community attachment.
   - Asian: A person having origins in any of the original people of the Far East, Southeast Asia, or the Indian Subcontinent, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
-Black or African American: A person having origins in any of the Black racial groups of Africa.
-Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
-Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture of origin, regardless of race
-White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa
-N/A

Nine Substantive Survey Questions

The following nine concrete survey questions, questions 5-14, accompanied by a reflection on the importance or justification for the inclusion of the subsequent question:

5. Have you ever personally struggled with mental illness of any kind?
   - Yes, and it was diagnosed
   - Yes, but it was never diagnosed
   - No
   - N/A

This question distinguishes the responses based on whether or not the subject seeks professional services and have an active diagnosis. Question 6 annotated below is not mutually exclusive of question 5, ordering the two questions ensures that the surveyor is paying attention, as it eliminates survey bias.

6. Have you ever seen a psychiatrist as a treatment option for your mental health concerns?
   - Yes
   - No
   - N/A

7. Have you have seen a psychologist as a treatment option for your mental health concerns?
   - Yes
   - No
   - N/A
Often times, individuals are confused with the differentiating professions. Subsequently, there are professionals who offer psychotherapeutic services combined with medication management as treatment options for patients.

8. *Have you ever been diagnosed by a medical or psychological professional with any of the following conditions?*

- Anxiety Disorders
- Bipolar Disorder (Manic-Depressive Illness)
- Delusions
- Depression
- Obsessive-compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)
- Other
- None
- N/A

Question 8 further specifies an active diagnosis the subject receives from the mental health profession. Although, not a comprehensive diagnostic list, these diagnoses are more common.

9. *How would you describe your current status with your mental illness?*

- Very Stable
- Somewhat Stable
- Somewhat Unstable
- Very Unstable
- N/A

10. *My acute mental illness made/makes it difficult to understand redemption.*

- Strongly agree
- Somewhat agree
- Neither agree or disagree
- Somewhat disagree
- Strongly disagree
- N/A

If subjects are not diagnosed with a specific mental illness by a mental health professional, and/or subjects are not comfortable with sharing details of their mental condition, question 9 will have a higher influx of ‘N/A.’ The answer choices in question 9 scale the stability
of the subjects’ mental illness, if the subjects select ‘Very stable’, further investigation into the contributing factors are considered, vice versa, selecting Very unstable.

11. “I believe a Christian with an acute mental illness can succeed spiritually even if the illness has not been treated.”
   - Strongly agree
   - Somewhat agree
   - Neither agree or disagree
   - Somewhat disagree
   - Strongly disagree
   - Don’t Know

12. “My acute mental illness weakens my efforts to live like a Christian.”
   - Strongly agree
   - Somewhat agree
   - Neither agree or disagree
   - Somewhat disagree
   - Strongly disagree
   - n/a

13. Have you ever sought pastoral counseling as a treatment option for your mental health concerns?
    - Yes
    - No

   If so, when was the last counseling session?
   - One month or less
   - Three to six months
   - Greater than Six months
   - N/A

Question 13 separates subjects based on if the subjects receive pastoral counseling, which data can be assigned quantitatively, how many actual subjects attend pastoral counseling, the timeframe, and moreover if there are statistically significant evidence that no subjects are attending counseling.

14. Do you agree that pastoral counseling sessions are beneficial in your treatment plan?
    - Strongly agree
    - Agree
    - Disagree
    - Strongly disagree
    - Not Applicable

15. Following the last pastoral counseling session, do you agree that there are recurrent struggles with your mental illness?
16. Have the symptoms of your mental health impairment improved since your last pastoral counseling session?
- Strongly agree
- Agree
- Disagree
- Strongly disagree

17. Do you agree others would benefit from pastoral counseling as a treatment option for mental illness?
- Strongly agree
- Agree
- Disagree
- Strongly disagree

18. “As I have dealt with mental illness, I have found the local church to be”
- Mostly Supportive
- Somewhat Supportive
- Neither Supportive or Unsupportive
- Somewhat Unsupportive
- Mostly Unsupportive
- Don’t Know
- N/A

19. Counseling sessions with my pastor have explicitly helped me think through and live out my faith in the context of my mental illness.”
- Strongly agree
- Somewhat agree
- Neither agree or disagree
- Somewhat disagree
- Strongly disagree
- Don’t Know
- N/A

Free Response: May select multiple answers:

20. Do you believe local churches should assist individuals with acute mental illness in any of the following areas?”
- Help families find local resources for support and dealing with the illness
- Talk about it openly so that the topic is not so taboo
- Improve people's understanding of what mental illness is and what to expect
- Increase awareness of how prevalent mental illness is today
- Provide training for the church to understand mental illness
- Offer topical seminars on depression or anxiety
- Have a counselor on staff skilled in mental illness
- Other please explain ______________________________
- Don't know
Appendix B

IRB Approval

December 24, 2019

Cynthia Taylor
IRB Exemption 3949.122419: Spiritually Guided and Bridging the Gap: An Inquisitive Analysis on the Correlation of Pastoral Counseling and Mental Health

Dear Cynthia Taylor,

The Liberty University Institutional Review Board has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under exemption category 46.101(b)(2), which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:101(b):

(2) Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if...the following criteria is met:

(i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects.

Please note that this exemption only applies to your current research application, and any changes to your protocol must be reported to the Liberty IRB for verification of continued exemption status. You may report these changes by submitting a change in protocol form or a new application to the IRB and referencing the above IRB Exemption number.

If you have any questions about this exemption or need assistance in determining whether possible changes to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,

G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

Liberty University | Training Champions for Christ since 1971
Appendix C

Consent Form

The Liberty University Institutional Review Board has approved this document for use from 12/24/2019 to -- Protocol # 3949.122419

CONSENT FORM
SPIRITUALLY GUIDED AND BRIDGING THE GAP: AN INQUISTIVE ANALYSIS ON THE CORRELATION OF PASTORAL COUNSELING AND MENTAL HEALTH
Cynthia Taylor
Liberty University
School of Divinity

You are invited to be in a research study on the correlation of pastoral counseling and mental health. You were selected as a possible participant because you are 18 years of age or older and a member of Deliverance Center for all Nations church. Please read this form and ask any questions you may have before agreeing to be in the study.

Cynthia Taylor, a doctoral candidate in the School of Divinity at Liberty University, is conducting this study.

Background Information: The purpose of this study is to determine if data suggests that members of the church are actively seeking pastoral counseling as an option to address current mental health issues, and if current pastoral counseling has impacted the congregation positively.

Procedures: If you agree to be in this study, I would ask you to do the following things:

1. Complete an anonymous survey that will take approximately 15-30 minutes.
2. Answer the survey questions provided to the best of your ability.

Risks: The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

Benefits: Participants should not expect to receive a direct benefit from taking part in this study.

Compensation: Participants will not be compensated for participating in this study.

Confidentiality: The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records.
- Participant responses will remain anonymous.
- Data will be stored on a password locked computer and may be used in future presentations. After three years, all electronic records will be deleted.

Voluntary Nature of the Study: Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time, prior to submitting the survey, without affecting those relationships.

How to Withdraw from the Study: If you choose to withdraw from the study, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study.
Contacts and Questions: The researcher conducting this study is Cynthia Taylor. You may ask any questions you have now. If you have questions later, you are encouraged to contact her at cetaylor8@liberty.edu. You may also contact faculty chair, Mario Garcia, at mgarcia3@liberty.edu.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, you are encouraged to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.