Quantitative Research on Peer-to-Peer Biblical Soul Care through the Encourager Program

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A Dissertation Proposal Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Education

School of Behavioral Sciences
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Abstract

This study sought to discover what impact a church program could have on personal well-being, spiritual well-being and church engagement, well-studied constructs in a variety of other clinical type settings. Quality, long-term research has been lacking in regard to the efficacy of pure, biblical soul care, a type of pastoral care methodology, that is provided strictly in a church setting. This type of research could allow for critical conversations about the larger ministry of soul care and potentially withstand scientific criticisms as biblical soul care becomes a proven, quantitative resource to help those who are hurting. The significance of this study is that it begins to provide a look at a potentially strong methodology that could test church programs for statistical significance. This study implements a quasi-experimental, pretest/posttest design, with a midtest measure added in an attempt to increase power analysis and further substantiate outcomes. Care Seekers attended the Encourager Program, a 3-session peer-to-peer biblical soul care program and provided frequencies and quantitative data points from an Intake and Feedback form at pre, mid and posttest. Sample size \((N = 5)\) showed no statistical significance in personal well-being \((p = .55)\) or spiritual well-being \((p = 1)\), largely due to lack in power analysis \((\beta > .50)\). However, this study showed promising beginnings for a methodological foundation to build upon in future studies. Recommendations for future researchers would be to continue improvement on design and methodology, as well as implementing additional ways of introducing biblical soul care to a general audience which could help reduce the stigma typically associated with counseling and mental illness. When it comes to caring for those who are hurting, the church must become equipped and respond in a way that is theologically rather than psychologically focused; this study means to bring encouragement toward that decisive action.

*biblical soul care, peer, Encourager, counseling, church, mental health*
Dedication

This work is dedicated to the ones who shaped it. To our children, Alexis, Joshua and Bryanna, who were birthed straight into the arms of Jesus and began this journey that put me right in the center of helping hurting people, because I become one of them. To my dad who passed away at the beginning of this work and left me with precious words that rang in my heart the whole way through, “I’m so proud of you baby girl! You can’t quit! Whatever you do, don’t give up!” To my mom-in-law who passed away in the middle of this work and left her son and me with the gift of knowing how very much she loved us and her grandchildren whom she met when she went to Jesus. To my mom, who passed away a couple of months before the very end of this journey and left me with the treasurable gift of seeing her transition from fear of dying to running into the arms of Jesus right before my eyes.

Most of all, to my husband Preston, who has walked every step of this life with me and encouraged me through every hard moment! I’m so glad we stayed after it. I love you, my king.
Acknowledgements

This work is marked and shaped by the very reason for it – brokenness and suffering in my own life; the kind that only Jesus and His church can heal. I am grateful and humbled the LORD would choose me to bring about a work that can hopefully bring the church back to the forefront in leading the way when it comes to helping the hurting by collaborating with mental health professionals.

I want to say thank you to my “stats angel”, Dr. Kathy Ewoldt. The LORD brought her directly to me out of nowhere and she was simply a game changer in helping me understand what needed to be understood. Additionally, to my pastors who let me plant the seeds of a vision God gave me years ago to help the hurting through the ministry now known as the LIFE Center. Thank you, Pastors Vance Pitman, Travis Ogle, J. Teddy Johnson, and Tom McCormick, for starting me on this crazy journey, for believing in me and leading me well – you truly are the greatest shepherds I could have ever asked for. To my family, especially to my sister, Vanessa Cain, who saw something in me years ago and always said I could; I love you sister.

As well, Jesus knew the kind of mentor and committee I would need to get me through the seasons I endured during this entire journey. I simply cannot see how I could have accomplished this without Dr. Whitni Buckles who tugged, pulled and challenged me in the best and perfect way at every right moment. Then, Dr. Melvin Pride came and fanned the flame even more with remarkable affirmations for the work God has planted in my heart. You both have helped me believe even more how important this work can be and to see, on a much larger canvas, that God never wastes pain, in fact, he eclipses pain that comes from the hardest moments in life. On this side, I am grateful I said yes.
PEER-TO-PEER BIBLICAL SOUL CARE

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*Spiritual well-being.*

*Church Engagement.*

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List of Abbreviations

Encourager Program (EP)

Personal Well-Being (pwb)

Spiritual Well-Being (swb)

Church Engagement (ce)

Duke Health Profile (DHP)

Duke Health Profile – Anxiety/Depression (Duke-AD)
CHAPTER ONE: INTRODUCTION

Overview

Research reveals that as the mental health crisis continues to grow, as does the number of people suffering who will seek help from clergy or pastors in churches as a first resource (Eliason, Lepore & Holmes, 2013; Abraham, 2014; Smietana, 2014; Stanford, 2014; Shorter, 2014 Jackson, 2015; Tan & Scalise, 2016; Stetzer, 2019). Rather than contact licensed mental health professionals more often, the church is the first point of contact when emotional or mental support is needed (Stanford, 2014; Stetzer, 2019). While there is a copious amount of empirical research and evidence supporting statistical significance on various therapeutic techniques in clinical and other settings to date, there is one controlled outcome study completed by Toh & Tan (1997) relaying the effectiveness of pure lay counseling in the context of the church (Tan & Scalise, 2016). Current and consistent empirical data supporting the validity of church programs administered through lay counseling or, as it is referred to in this study, peer-to-peer biblical soul care, is minimal. This body of research focuses on the impact a peer-to-peer, biblical soul care church program has on personal well-being, spiritual well-being, and church engagement as it relates to engaging in small group, serving, or going on a mission trip. Since the church is among the first of many resources a person makes contact with when in distress, it is advantageous for the church to first understand itself as a chief resource for those who are hurting, to lean into being equipped to assist those who reach out for help, and in order to boast confidence in its effectiveness, have up to date, empirically researched data showing efficacy in personal well-being, spiritual well-being and church engagement, just as the professional community provides. This quantitative study is designed to investigate how a peer-to-peer biblical soul care ministry, provided through the intervention of the Encourager Program, and offered specifically in the
context of the church, can impact a Care Seeker’s personal well-being, spiritual well-being, and church engagement.

**Background**

Recently at the American Association of Christian Counselor’s (AACC) World Conference, Dr. Matthew Stanford (2019) gave a clarion call for the church to step up and lead the way in the mental health crisis we currently face (AACC World Conference Plenary Session, 2019). Dr. Stanford suggests four primary qualities the church embraces which could potentially strengthen the mental health field, as well as make the church a more natural fit within the field. Those qualities are hope, a wholistic view, accessibility, and therapeutic communities (Stanford, 2019). These four qualities will be discussed more in depth in the literature review in chapter 2, but the significance of the church’s potential role in the current mental health crisis cannot be overstated. Dr. Stanford stated plainly, “We are community, and community is therapeutic” (Stanford, 2019). If the church is being called upon as a front-line resource by those who are in distress, this cannot be a clergy only problem, but rather a church, or a spiritual community responsibility where care for those in distress originally began as early as the 20th century (Crabb, 1997; Crabb, 1999; Cole, 2010; Abraham, 2014; Rogers & Stanford, 2015; Avent, Cashwell & Brown-Jeffy, 2015; LaMothe, 2018; Iheanacho, Stefanovics & Ezenolue, 2018; Stanford, 2019).

**Historical and Social Context**

In the early 1900’s (1905-1929), a failed attempt, known as the Emmanuel Movement (Maynard & Snodgrass, 2015), brought psychotherapy into the world of pastoral care and counseling in the church setting. Scholars have concluded that the supposed failure of integration between pastoral care and secular counseling may have been caused by an ongoing distrust
between physicians and clergy that developed over time (MacArthur, 2005; Powlison, 2010; Jackson, 2015; Maynard & Snodgrass, 2015). Physician skeptics believed pastoral counselors who were providing care for the mentally ill in the church, were confusing their theology with therapeutic practices and attempting to combine the two without proper training (MacArthur, 2005; Powlison, 2010; Jackson, 2015; Maynard & Snodgrass, 2015). Even after the alleged failed attempt at integration, additional problems persisted in determining the role for pastoral counseling in the mental health profession. The additional problems were due to a lack of testable theories, efficacy, and even concerns regarding the monetary values of these type of services provided within the church. (VandeCreek, Bender & Jordan, 1994). The effects of clergy implementing methods of pastoral counseling lacks even minimal research surrounding appropriate credentialing, methodologies, and consistent, quantitative measurements on clergy and church members as pastoral care givers or biblical counselors (Townsend, 2011; Eliason, Lepore & Holmes, 2013).

However, before consideration in the feasibility of offering a peer-to-peer biblical soul care approach, there is an important set of attitudes toward this notion that should be better understood. In the attempt to integrate in the early years, pastoral assumptions at the time were many. One of which was the attitude that pastoral counseling and care were exempt from such scientific rigor because it could violate the purity of God’s grace, which should not be reduced to numbers (VandeCreek, et al, 1994). Later, theorists would argue that efforts to explore how the issue of providing pastoral counseling and care should not solely be a matter of proving efficacy for the sake of billing and monetary gain, but rather a matter of seeking collaboration with secular professionals (VandeCreek, et al, 1994). It is the idea of collaboration the researcher desires to bring back to the forefront of thought by investigating the efficacy of pure, peer-to-
peer biblical soul care administered through a church program. Seeking collaboration between the church and mental health professionals could effectively bring about a holistic view of healing to the heart, mind, and soul of a person in distress.

Another more recent attitude toward mental health and the church is the perception that clergy and congregants hold toward mental illness (Stanford, 2007). In a study to discover attitudes toward mental illness in Christian churches, Stanford (2007) reported that although the majority of those who contact the church first due to experiencing a mental illness felt like they were accepted, there were still approximately 30% who self-reported a negative reaction from those in the church (Stanford, 2007). The researchers who conducted the study asked 293 self-identified Christians (181 females, 112 males) five questions about their experience with the church when reaching out for help. The majority responded there was a positive response, but it is the 31.4% the researcher seeks to bring attention to. This smaller population responded that the church made them feel like their mental illness was a result of sin; and those who were seeking help only were looking for attention rather than actual help. Another 32.4% said the church insinuated the participant, or their loved one, did not really have a mental illness even though they were professionally diagnosed. 18.4% were discouraged from taking medication, and 2.7% were outright forbidden to take medication by the church. Further, 25.9% reported their problem became worse after the church’s involvement, 36.2% said their interaction with the church weakened their faith, and 12.6% said they are no longer involved in the faith because of their interaction about their mental illness with the church (Stanford, 2007).

These positions are the very reason more studies, such as this one, which provide scientific outcomes on peer-to-peer biblical soul care provided in the context of the church, need to occur on a more consistent basis. The results of Stanford’s (2007) research, at a minimum
challenge, if not demand for the church to take the necessary steps to prepare in leading in the provision of care to the souls of those who are suffering or are in crisis. It is this type of study that could help reduce the stigma surrounding mental health in the church (Stanford, 2007; Jasko, 2012; Capps, 2014; Stanford, 2014; Stetzer, 2016). As well, this type of study could increase the confidence of those who seek help from the church, elevate the level of biblical soul care from supposed incompetence to professionalism, and even more important it could help stabilize a person in distress. Additionally, properly training volunteers, not only to provide appropriate biblical soul care, but also on how to offer proper referrals as needed, and effectively collaborate with licensed professionals, could theoretically strengthen the field of mental health. Doing so could better position the church to come alongside the clinical setting as a reliable, trusted partner, all while the church holds to its primary responsibility of maintaining the purity of God’s grace as previously mentioned. This transition into healthier attitudes and understanding, aids in providing clarity to the distinction of pastoral counseling versus pastoral care.

**Pastoral Counseling or Pastoral Care**

With pastoral counseling emerging as a profession poised to help community members, it is essential to differentiate between pastoral counseling and pastoral care. The following provides a distinction between pastoral counseling offered by pastors trained in counseling techniques, usually through a higher education, and pastoral care that is provided by trained peers who are church members and trained specifically in a church setting. One of the clearest explanations of the differences between the two is found in an article exploring the contributions of Donald Capps written by Dr. Ryan LaMothe (2018). Donald Capps, an American theologian, was a significant contributor to the field of psychology of religion, and a teacher to seminarians who desired to offer pastoral counseling (LaMothe, 2018; Dykstra & Carlin, 2018). In a recent
article, LaMothe (2018) highlights Capps’ (1998) summation of pastoral counseling, noting it to have two main tenants: the importance of human storytelling and the image of the Shepherd found in the Bible. Capps (1998) made the argument that while both pastoral counseling and pastoral care involve listening to human storytelling in the context of providing care, in pastoral counseling, the care giver attends to, listens to, and seeks to understand individuals in a therapeutic way. On the other hand, in addition to attending, listening and seeking to understand, pastoral care takes the human story at face value and does not attempt to connect the story to an underlying cause, disorder, or provide therapeutic technique (Capps, 1998; LaMothe, 2018). Furthermore, the activity of pastoral care points to an image of the Shepherd found in the Bible known as Jesus, and it is also known as a way for lay counselors, or designated church members, to provide support and crisis care (Doehring, 2019) directly from the church setting. With this understanding, this study examines pastoral care in the way of peer-to-peer biblical soul care provided in the context of the church.

**Problem Statement**

The foundational problem this study is designed to explore is what impact a church program could have on three dependent variables, personal well-being, spiritual well-being and church engagement. With no current church program studies available in the world of research for evaluation, there is a great need for more studies of this kind. A study such as this one could provide empirically sound evidence, showing whether or not there is a statistically significant difference in the previous mentioned variables, after the intervention of a church program is applied: a program such as the Encourager Program. This lack in empirically based research on peer-to-peer biblical soul care through a church program, provides the foundational rationale for this study and lends to the necessity and importance for this investigation.
Moreover, this research seeks to return attention to the importance of involving the church in the care of those who are suffering, or in crisis, by empirically validating the effectiveness of an intervention such as the Encourager Program. In this study, the Encourager Program was conducted in the context of the church and provided by trained church members referred to as Encouragers. With more than 85% of those who experience a crisis calling the church first (Eliason, Lepore & Holmes, 2013; Abraham, 2014; Smietana, 2014; Stanford, 2014; Jackson, 2015; Tan & Scalise, 2016; Stetzer, 2019), preparing to care for those individuals with trained, volunteer peers, becomes a significant attribute the church must embrace now, more than ever before. As stewards of God’s resources, with people being God’s primary resource, the church should transition to developing an obligation to meet the needs of those in crisis with audacious courage and readiness.

**Purpose Statement**

Again, the purpose of this study is to determine whether or not a peer-to-peer biblical soul care ministry, offered specifically in the context of the church, can make a difference in the personal well-being, spiritual well-being and church engagement of those who are suffering, or in the midst of a crisis. Participants for this study are those who contact the LIFE Center at Hope Church in Las Vegas, NV, and request peer-to-peer biblical soul care. The participants will be referred to as Care Seekers for the remainder of this study. Care Seekers meet with peer church members who are trained to provide intervention through the Encourager Program. The Care Seeker participated in a pre, mid and posttest assessment to test if there would be a statistically significant difference in the measured variables, personal well-being, spiritual well-being and church engagement. This quantitative study could add to the minimal body of literature already submitted on lay counseling and integrative methods and aid in developing reliable resources.
that could potentially increase confidence in a peer’s abilities to help those who seek care through the church. Additionally, this kind of study could rebuild trust and begin a healthy collaboration between professionals in the mental health field and the communities of pastors, clergy, and trained church members. Bridging the gap could bring about a stronger association between the secular mental health community and the church.

**Significance of Study**

The significance of this study brings distinct meaning and efficacy to peer-to-peer biblical soul care in the context of the church. Additionally, it begins filling a gap in the literature on the impact peer-to-peer biblical soul care has on the constructs of personal well-being, spiritual well-being, and church engagement. Results from this study could rekindle conversations surrounding church care and begin a strong, trusting alliance between the church and mental health professionals in an effort to holistically care for those who are mentally and emotionally suffering. The impact researched based peer-to-peer biblical soul care could have on the totality of the field of mental health is theoretically substantial. The enormous lack of evidence-based peer-to-peer biblical soul care produces a gap in evaluated church program designs, controlled experiments and other empirically based designs. A quasi-experimental design does not allow for random selection and in the case of this study, there was not a control group due to the intake process later described in the methodology. However, as previously stated, the design for this study is proven appropriate due to the nature of the pre, mid and posttest design. This research has an ultimate goal of renewing interest in scientifically backed evidence for biblical soul care through church programs, opposed to more philosophically based theories on soul care in general.
If indeed findings discovered from a self-report assessment by Care Seekers who are mentally suffering or in the midst of a crisis, produces a statistically significant difference in personal well-being, spiritual well-being and church engagement, the outcomes could potentially change the industry and how licensed professionals view the role of the church in mental health, as well as how the church views the role of licensed professionals. The results can theoretically strengthen collaboration that does not get in the way of the one seeking care, but rather creates a holistic system of care in a cooperative effort and benefits the one who deserves it most – the mentally and emotionally ill who increasingly seeking care from the church first.

**Research Questions**

There are 6 questions asked in this study: Does personal well-being increase after mid-test when compared to pretest, and does personal well-being increase after posttest when compared to pretest? Next, does spiritual well-being increase at mid-test when compared to pretest, and does spiritual well-being increase at posttest when compared to pretest. Finally, does church engagement remain the same or increase at mid-test when compared to pretest, and does church engagement remain the same or increase at posttest when compared to pretest. These questions will be discussed in greater detail below. However, it should be noted that the questions the researcher poses stem from assumptions she holds and are developmentally critical to help withstand scientific criticism due to this type of study’s bent toward qualitative measures and results. Providing quantitative evidence to the qualitative nature this type of study produces, helps peer-to-peer biblical soul care become a stronger ally in the scientific community without having to compromise its Biblical call to discipleship and community (Crabb, 2015; Matthew 28:19-20). In the next section, the researcher draws out her progression in thinking, beginning with initial assumptions held that were brought about by the research questions.
Assumptions

Like all studies, this investigation was designed with some important assumptions in mind. Although a good amount of research revolves around the church integrating proven therapeutic practices and more recently, clinicians integrating spiritual practices into their therapies (Garzon, 2009; Entwistle, 2010; Garzon, 2014), a first assumption noted by the researcher is that if the church were to provide pure, peer-to-peer biblical soul care in the context of the church, and then partner with clinicians, rather than integrate clinical therapeutic techniques on either side, a healthier collaboration could occur with a greater amount of trust, elimination of confusion, and the possibility of harm to the one seeking care. Integration in and of itself is not being purported as unhealthy or harmful; rather, collaboration is being proposed as another option to potentially expose a similar efficacy to secular counseling or integration, both of which have already been vigorously investigated. The only way to discover efficacy in pure, peer-to-peer biblical soul care is through repeated studies like this one.

A second assumption the researcher has is that there could be great success in the use of a church program as an intervention that is administered by a trained church member. Such success becomes possible because of the presupposition that as the Holy Spirit of God moves through a church member, who has confessed Jesus as their Savior, he could provide the kind of help, healing, care and connection to community a disconnected soul needs when suffering or in crisis (Adams, 1970; Crabb, 1977; Crabb, 1999; Capps, 1998; Collins, 2007; Powlison, 2010; Kollar, 2011; Lambert, 2012; Crabb, 2013; Capps, 2014; Ortberg, 2014). This is not to say peer-to-peer biblical soul care is an only solution, but rather an additional solution that remains pure in its form, and again, allows trained peers to seek collaboration with secular, licensed professionals who practice in their own pure, therapeutic techniques. This kind of collaboration
creates a *both/and* methodology of caring, rather than an *either/or* methodology, and reduces, if not eventually eliminates, the battle between science and faith in the specific arena of mental health.

A third and final assumption is that peer-to-peer biblical soul care is indeed a viable solution which could come alongside clinical care. It is not something that overrides or replaces clinical care, but a practice that could become a viable, scientifically proven methodology to enhance and provide a holistic approach to those who seek care. The vast gap in literature and lack of empirically based evidence on peer-to-peer biblical soul care, offered in the context of the church through program evaluations, provides the overarching basis for this study and led to the following research questions:

**RQ1:** Is there an increase in personal well-being after session 2 (mid), compared to pretest, when a Care Seeker participates in the Encourager Program?

**RQ2:** Is there an increase in personal well-being after session 3 (post) compared to pretest, when a Care Seeker participates in the Encourager Program?

**RQ3:** Is there an increase in spiritual well-being after session 2 (mid), compared to pretest, when a Care Seeker participates in the Encourager Program?

**RQ4:** Is there an increase in spiritual well-being after session 3 (post) compared to pretest, when a Care Seeker participates in the Encourager Program?

**RQ5:** Is there a difference in church engagement after session 2 (mid), compared to pretest, after participating in the Encourager Program?

**RQ6:** Is there a difference in church engagement after session 3 (post), compared to pretest, after participating in the Encourager Program?
Definition

Next, it is beneficial to define the terms used throughout this study to bring clarity and dissolve confusion on the commonly used expressions generously spoken throughout the mental health field and the church when it comes to care, counseling, etc. The following definitions provide a sharper focus on what this particular body of research is concentrated on.

1. **Peer-to-Peer Biblical Soul Care** – The term most often used when speaking of care or counsel provided by church members is lay counseling, or counseling provided by laity (Tan & Scalise, 2016; Lotter & Van Aarde, 2017). Laity refers to church members and is made distinct from clergy, most often when it comes to caring for those in the church (Lotter & Van Aarde, 2017). In this study, laity and peers are synonymous and are equipped by clergy and the leaders of the church who are more advanced in training to care for their peers (Ephesians 4:11-12). Peer-to-peer biblical soul care is one-on-one biblical soul care provided in three sessions through the intervention of the Encourager Program.

2. **Encourager** – Encourager literally means to impart courage (Seacoast Church, 2018). An Encourager is a trained church member through Foundation’s training, explained in more detail later, and is a peer of a Care Seeker. An Encourager typically does not hold a church staff position but is a volunteer who has indicated a call to minister in a church setting to those who are hurting or in a crisis.

3. **Care Seeker** – A Care Seeker is equivalent to a what the mental health field refers to as a client. To eliminate confusion and crossover, a person seeking peer-to-peer biblical soul care through the Encourager Program at the church is referred to as a Care Seeker.

4. **Personal Well-being** – Personal well-being is defined as overall well-being in the areas of physical and mental health, and an ability to thrive in social functioning (Parkerson, Eisenson
and Campbell, 2019; World Health Organization, 2008). In this study, personal well-being is operationalized as it specifically relates to anxiety and depression.

5. **Spiritual Well-Being** – Spiritual well-being is defined by the architects of the scale as a general indication of perceived well-being in self through two sub-measures, religious and existential well-being (Ellison & Paloutzian, 1983). The *Spiritual Well-Being* scale is a quantitative, 20-point self-report scale created by Craig W. Ellison & Raymond F. Paloutzian (1983).

6. **Church Engagement** – The construct church engagement is defined by the researcher as length of time a person has attended a church, in this case Hope Church; and measured involvement, specifically in the areas of serving, joining a small group and going on a mission trip. Studies consistently show a correlation between religious involvement or church attendance to better health outcomes (Mueller, Plevak, & Rummans, 2001; Koenig, 2012; Peteet & Balboni, 2017).

**Summary**

The first chapter in this study, entitled “Introduction”, has provided an overview of the rationale for this quasi-experimental analysis; a discourse on the background, and a historical and social context overview of care for those in distress. Additionally, distinctions between pastoral counseling and pastoral care were identified. Followed by sections stating the problem and purpose statement, the significance of this type of investigation, and the research questions and definitions. Chapter one presents with the intention to provide a well laid foundation for the chapters to follow. Beginning with chapter two, which provides the reader with an historical understanding of the literature surrounding the topic of biblical soul care in the context of the church. Then, in chapter three the methodology used to determine the statistical significance the
Encourager Program had on a Care Seeker is described. Chapter four presents the findings through descriptive statistics and the results to the hypotheses posed in this research project. Lastly, chapter five discussed the conclusions, implications, limitations and recommendations for these types of studies that could uphold the importance of scientifically validated results on the impact a church program could have on personal well-being, spiritual well-being and church engagement. The results of this study could create the necessary, well-built bridge between trained church members and licensed professionals to potentially reverse the current rampant increase in the mental health crisis.
CHAPTER TWO: LITERATURE REVIEW

Overview

An underlying goal of this study is to build on the limited amount of research surrounding pure, peer-to-peer biblical soul care methodologies offered in the context of the church. This study is meant to initiate renewed discussion and scientific relevance to church programs that may or may not include some humanistic approaches and concepts, often considered a “third force” in psychology (Jones & Butman, 2011; Wong, 2016;). In an attempt to show comparable, empirical relevance when using similar techniques that are intentionally or unintentionally integrated into some church programs, this study offers a focused look at a pure, peer-to-peer biblical soul care methodology, administered in a one-on-one setting within a church setting. Specifically, this study seeks to investigate the impact the Encourager Program can have on personal well-being, spiritual well-being and church engagement. Up to date scientific evidence on peer-to-peer biblical soul care counseling ministries can potentially develop ongoing, collaborative discussions between the church and the mental health community. Positive outcomes could bring about a greater regard and respect for care provided in the church by trained peers, and bridge the gap and mistrust developed over the years between care givers in the church and secular care professionals providing evidence-based secular therapeutic techniques (Crabb, 2005; Lambert, 2012; Jackson, 2015).

The following literature review forms the theoretical framework to demonstrate how peer-to-peer biblical soul care could impact the dependent constructs of well-being and engagement, as well as to show how the results of this type of study could contribute to the current body of research on quantitative outcomes in the field of mental health. First, this literature review starts with a look at a broad, historical overview of mental health during the 19th and 20th centuries, followed by the
state of mental health in the 21st century. Next, a brief historical look at Christian counseling, pastoral counseling and pastoral care provided in a church setting, its journey from the church, into the arena of secular psychology and psychiatry and back to the church with the inclusion of integration. Next, this literature review will discuss the peer-to-peer biblical soul care methodology known as the Encourager Program and any intentional or unintentional ties to the humanistic theory of counseling. Finally, this study looks at four care constructs tested in this study: the Encourager Program, personal well-being, spiritual well-being, and church engagement.

**Introduction**

As previously stated, the goal of this study is to bring quantitative values to biblical soul care that is provided in a church setting through a peer-to-peer biblical soul care methodology. Doing so potentially demonstrates that soul care provided in the church could effectively position itself alongside secular counseling provided in clinical settings. Church programs, such as the Encourager Program, are a much-needed resource to help equip believers in Jesus in preparation for the increase of people seeking help through the church when they are in crisis. In fact, research reveals that when people are suffering from mental illness, or suffering through a crisis, they will often first seek help from a pastor or clergy at the church (Eliason, Lepore & Holmes, 2013; Smietana, 2014; Stanford, 2014; Abraham, 2014; Smietana, 2014; Jackson, 2015; Tan, 2011; Tan & Scalise, 2016; Stanford, 2019; Stetzer, 2019). And yet, with the growing popularity of the church as a front-line resource for those who suffer (Stanford, 2008; Smietana, 2014; Stanford, 2014; Tan & Scalise 2016), evidence on the efficacy of a pure, peer-to-peer biblical soul care offered in the church setting, is still minimal (Tan & Scalise, 2016).

The remainder of this chapter will provide an in-depth rationale for why this study is imperative; beginning with a brief history on how counseling moved from the church to clinical
settings, and how that lent to the distrust between professionals and clergy. Second, a look at the state of mental health in the 21st century, and how the conflicts that developed in the years prior, were potentially a part of the reason for its lack of success. Third, an effort is put forth to bring clarity to the various types of counseling, why it is important to make a clear distinction between pastoral counseling and pastoral care, and why it is key to clarify what the church is actually providing when it administers soul care. Fourth, this study proposes the Encourager Program, a type of pastoral care, as a viable solution that could potentially increase well-being and engagement in the church community. As well, efficacy provided on the Encourager Program could also facilitate respect from the professional community of mental health. Fifth, a detailed discussion on how the Encourager Program impacts the three dependent variables examined in this study, personal well-being, spiritual well-being, and church engagement. Finally, this literature review will be brought to a close with a conclusive discussion as to the consequences of this type of study and how the methodology discussed is a proper way to start.

The investigation of church programs offered strictly in a church setting, specifically those that are in a one-on-one context, are much needed in order to provide scientific validity and efficacy to peer-to-peer biblical soul care offered to those who are suffering. These kinds of studies could lead to a growing number of one-on-one and group type biblical soul care methodologies in becoming a reliable, empirically sound resource in the community of science and mental health. This literature review provides the foundation to this discussion starting with a broad, historical overview of mental health.
Historical Overview of Mental Health

19th and 20th Centuries

Stemming from a Freudian belief system which began taking hold of the clergy’s way of thinking as they cared for those in their parish, more often, pastors were provided a psychological rather than a theological lens, to view the human condition. The Freudian focus on the human condition as a psychological issue, rather than a soul issue, eventually led pastors to believe that problems presented by those in their parish, extended beyond theological practice and required a specialized training in psychotherapeutic methods (Maynard & Snodgrass, 2015).

Then, in the early 1900’s (1905-1929) Emmanuel Church in Boston, put forth a failed attempt, known as the Emmanuel Movement. This movement integrated psychotherapy back into the world of pastoral counseling and care within the context of the church (Maynard & Snodgrass, 2015). Fifteen years after the movement started, in the early 1920s, relations between clergy and physicians eroded and blame for the movement’s failure landed on the assumption that, once again, distrust grew between physicians and clergy (MacArthur, 2005; Jackson, 2015; Maynard & Snodgrass, 2015). With that as the common view, physician skeptics believed pastoral counselors were confusing their theology with therapeutic techniques and attempting to combine the two methods without proper training (Adams, 1970; MacArthur, 2005; Crabb, 2005; Bledsoe, Setterlund, Connolly & Adams, 2011; Lambert, 2012; Jackson 2015). Thus, counseling for those who were suffering once again moved to the secular world of mental health (Powlison, 2010).

Scholars in historical writings have noted that almost all counseling in the 19th and 20th centuries, moved from its origins of being provided by clergy in the church, to trained and educated professionals outside of the church (Adams, 1970; VandeCreek, Bender & Jordan, 1994; MacArthur, 2005; Powlison, 2010; Lambert, 2012). At the end of the Emmanuel
Movement, the transition of counseling from clergy to secular professionals, came at a time when modernism began to dominate the thinking of society in the late 19th and early 20th centuries (MacArthur, 2005; Lambert, 2012; Kuiper, 2020). As Charles Darwin made a clear break from religion in his *Origin of Species* writing in 1859, Darwinism created a devastating crisis for Christianity as the philosophical thought challenged the origins of humanity written in Genesis, the first book of the Holy Scriptures (Fitch, 1959; Cohen, 1984; Ruse, 2007; Lambert, 2012). As Darwinism invaded and took hold of thinking in a modernist society, it undercut the authority and confidence of pastors and ministers in the church. All the undercutting, loss of confidence, and invasion soon impacted how parishioners were cared for by clergy who became more theoretically focused versus theologically dedicated (MacArthur, 2005; Ruse, 2007; Cole, 2010; Lambert 2012; Jackson, 2015). Over time, the practice of counseling evolved from ministry within the church to psychotherapy in secular venues, causing counseling provided in the church to nearly disappear in the psychological revolution (Adams, 1970; Adams, 1979; Crabb, 2005; MacArthur, 2005; Clinebell, 2011; Lambert, 2012; Jackson, 2015).

In light of the confusion that developed between clergy, psychotherapists and psychiatrists, a different approach was presented toward the commonalities and differences in pastoral care and psychiatry in an article written by Reverend Rollin Fairbanks (1947). Fairbanks (1947) indicated that in order to benefit the well-being of the client, the need for pastoral care and psychiatry to cooperate and collaborate, rather than work against one another, was vital (Spiegleman, 1984; Crabb, 2005; Park, 2006; Newman, 2009; LaMothe, 2014; Jackson, 2015). In the late 1970’s, numbers became a critical factor in the behavioral sciences. In order for behavioral health care to remain accessible to people who needed this type of care, health care facilities were forced to look at efficacy and cost effectiveness (VandeCreek, et al, 1994).
Quality assurance departments were created to ensure that practices being performed in the health care industry were meeting the standards necessary for billing (VandeCreek, et al, 1994; Royse, 1985).

In this time of modernism, confusion and transition, the risk of violating the purity of God’s grace was considered far more concerning than any assumptions held about pastoral counseling and care being able to withstand the rigors of scientific values. (VandeCreek, et al, 1994). One could maintain how the issue of providing pastoral counseling and care to an individual, should not solely be a matter of proving efficacy for the sake of billing and monetary gain, but rather become an effective delivery system of biblical soul care to be administered to a person seeking help through the church. This kind of peer-to-peer biblical soul care could be administered by those who believe in the teachings of Jesus. Provision could be from those who attend intensive biblical training provided through the local church, such as Foundations Training, a 5-week training provided to all those who wish to be an Encourager in the LIFE Center. For those who believe in Jesus and attend training, they could then effectively extend all the one another’s that the Apostle Paul writes about extensively throughout the New Testament (Adams, 1970; MacArthur, 1995; Crabb, 2005; MacArthur, 2005; Lambert, 2012; Tan & Scalise, 2016) to those in crisis or who are suffering. Peer-to-peer biblical soul care, administered in a church setting at no cost, could benefit those who are suffering and who seek counseling and care through the church. The benefit could be seen in such a way that it could potentially improve a person’s well-being and increase involvement in the church. Doing so could help overcome obstacles such as cost and availability issues (Fairbanks, 1947; VanderWaal, Hernandez & Sandman, 2012), making care for those who are suffering more accessible through the church. Continuous studies on biblical soul care and other church programs could add
scientific validity to the secular field of psychology and psychiatry, as well as bring about a much-needed collaboration between secular counseling and biblical soul care. Doing so could potentially improve the mental health crisis in the 21st century and beyond.

**The State of Mental Health in the 21st Century**

In nearly twenty years, the number of people impacted by mental illness has not drastically changed. Although Mental Health America (2017) reports relative stability in mental health conditions, suicidal ideation shows an increase from 3.77% in 2012, to 4.19 percent in 2017 among American adults (MHA, 2017). Pertaining specifically to mental illness, in 2001 The World Health Organization (WHO, 2001) reported that 1 in 4 people in the world are personally impacted by a mental disorder (WHO, 2001; Stanford, 2014). Reported in March 2021 by the National Alliance of Mental Health (NAMI), 1 in 5 U.S. adults experience any mental illness (AMI) annually, and 1 in 25 experience a serious mental illness (SMI). AMIs and SMIs are both defined as having a mental, behavioral, or emotional disorder. The distinction between an AMI and an SMI is mostly determined by the length of time the disorder substantially interferes with normal life activities (NIMH, 2019). In a church congregation of 3,000 that would be 600 individuals with any mental illness and 120 with a serious mental illness. This does not include those who do not self-report or consider themselves as struggling with mental illness such as those who live in high stress, toxic environments, or those who simply need wise counsel for a situation occurring in their lives. In addition to the article on stigma mentioned in chapter 1, another article written by Ed Stetzer (2016) on stigma surrounding mental health issues within the church, noted that while only 22% of pastors report being reluctant to getting involved with those who suffer from mental illness, 68% of pastors agree that the church should maintain a list of local mental health resources, but only 28% of
families agree that they have been made aware of resources for the mentally ill in their church (Stetzer, 2016).

NAMI reports that 56% of adults did not receive or have access to treatment for mental health (MHA, 2017; NAMI, 2019). As noted earlier, a few reasons the church has become a frontline resource for those suffering with a mental illness, or who are in a crisis, are the obstacles presented to get the kind of care that would be affordable and easily accessible in the secular counseling arenas. In addition to stigmas, additional obstacles to not having enough mental healthcare professionals are a shortage of psychiatric facilities, no transportation, limited financial resources, a lack of knowledge and education, shame, and misguided cultural beliefs (VanderWaal, Hernandez & Sandman, 2012; Stanford, 2014). While the percentage of adults who did not receive care dropped slightly from 59% reported in 2011 to 56% reported in 2019, the number of adults who actually did not receive or have access to proper care (44%) is still a large part of the total population of the mentally ill (MHA, 2017; Stanford, 2008; Stanford, 2014; Smietana, 2014; Stetzer, 2016, Tan & Scalise, 2016).

Being on the front lines as a first point of contact, the church must take seriously the preparation of church members to help those who are suffering and become capable of providing peer-to-peer biblical soul care. Another option the church could include helping to eliminate the fear or uncertainty that church peers might develop as a result of not being educated in psychotherapeutic techniques. Fear and uncertainty could potentially be challenged by implementing distinct training that brings clarity to what is being provided in church settings. Additionally, clergy and peers could continue cultivating concern for how to integrate psychology and the bible in the best way possible as a way to serve those who are hurting. Rather than remain stuck in fear, uncertainty and concern, God’s people could ideally provide
the kind of relief needed by administering pure, peer-to-peer biblical soul care, making it possible to detect mental health issues in those seeking care, and refer, as needed, to clinical or mental health professionals to facilitate a healthy collaboration. Providing this type of specific soul care, could provide the opportunity for the Care Seeker to work through some of the presenting psychological and physiological issues. This opportunity could assist in promoting health in a person’s soul through the efforts of a peer administering biblical soul care.

As mentioned earlier, at the 2019 American Association of Christian Counselors (AACC) World Conference, Dr. Matthew Stanford issued this type of call for the church to once again rise up to care for those who are suffering. Dr. Stanford (2019) directly called upon care givers in the church to position themselves to take the lead on delivering soul care to those who are suffering and encountering mental health issues (Stanford, 2008; Smietana, 2014; Stanford, 2014; Tan & Scalise 2016; Stanford, 2019; Stetzer, 2019). It seems the most specific debate that continues at the forefront, where no debate needs to exist (Fuentes, 2015; VanderWaal, Hernandez & Sandman, 2012; Jackson, 2015), is between science and religion. Biblical counselors continue questioning the science of mental health, and mental health professionals remain suspicious toward religious beliefs and whether or not pastors and church members have a place in counseling those who are suffering (McMinn, Staley, Webb & Seegobin, 2010; Powlison, 2010; Stetzer, 2014; Fuentes, 2015; Jackson, 2015; National Academy of Sciences, 2017).

There are clear circumstances when licensed professionals, who are well-trained and qualified, are needed for the specialized type of care they provide, to work with the more serious mental illnesses that make up the 1 in 25 of adults in the U.S. (NAMI, 2019). And perhaps in some cases, should take the lead in the collaborative relationship when a mental health disorder
is dominant. Professionals trained in specific areas such as cognitive-behavioral therapy (CBT), mindfulness-based cognitive therapy (MBCT), post-traumatic stress disorder (PTSD) or any other AMI or SMI, are necessary to care for those suffering with these specific mental disorders. While mental health professionals are needed, commonly used modalities such as CBT are not a cure-all. For instance, some scholars examining CBT’s effectiveness, specifically speaking to the treatment of depression and anxiety, the top two reported mental disorders (NAMI, 2019), speculated that the effectiveness of CBT could potentially be overstated, and is generally associated with lower scores at 6-month and 1-year follow ups (Butler, Chapman, Forman & Beck, 2006; Tolin, 2010; McMain, Newman, Segal, Derubeis, 2015). Another team of scholars in 2010 conducted a meta-analysis on MBCT’s effectiveness in alleviating symptoms of depression and anxiety. Researchers discovered that MBCT, considered to be a “new wave” or “third wave” form of CBT, was only moderately effective. Before accepting any of the above findings, greater, more detailed studies should be conducted over a lengthy period of time to adequately test these hypotheses so that there is a truer understanding of its efficacy. (Hofmann, Sawyer; Keng, Smoski, Robins, 2011). The above studies are not yet substantiated and leave room for further investigation to appropriately answer questions that remain regarding how to best help those who are suffering. Additionally, it would be prudent to note what is not being stated; that proof of ineffectiveness of any modality is not an implication of them not being useful. Rather, a modality administered by a trained professional, in collaboration with biblical soul care by a trained peer could better serve the holistic healing process of a person who is in the midst of a crisis. Deeper investigation would help legitimize the pursuit of other interventions such as peer-to-peer biblical soul care that also exercises the use of proper referrals. Doing so places priority on the well-being of the Care Seeker, helping to ensure no harm (AACC, 2014).
Again, regardless of a mental illness, acknowledgement of the soul is vital in the care of a person. This does not mean clinicians and mental health professionals are no longer needed or should turn away from helping those who also have spiritual needs, but instead should also seek to collaborate. Every person who presents with either a crisis or a mental illness recognized in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) has a soul.

Bringing clarity to the confusion in the meaning of the type of care provided to a person in distress and creating an environment where a singular focus on administering biblical soul care can occur, could be part of a first step. This first step could help assist in resolving the ongoing, existing debate between the authority of Scripture and science. Doing so could also help members of the church begin to cultivate the courage it would take to come alongside those who are suffering and provide a safe place for a richer connection to the healing love of Jesus Christ (Crabb, 1977; Crabb, 2005; Abraham, 2014). Crabb (2005) suggests that underneath all the psychological and neurological disorders is a disconnected soul. In that case then, administering peer-to-peer biblical soul care in a church setting with unconditional positive regard, consistency and gentleness, without judgment or criticism, in collaboration with a professional who provides psychological therapeutic care administered in the secular world, could help someone discover the kind of peace that grounds the individual in stability, and brings about the administering of proper care to the whole person (Crabb, 1999; Clinton & Ohlschlager, 2002; Crabb, 2005; Hofmann, Sawyer & Fang, 2010; Tan, 2011; Abraham, 2014; Ortberg, 2014).

To help build upon these important characteristics, biblical soul care that required unconditional positive regard administered by trained peers in the church in a one-on-one setting,
can over time help lessen the mental health crisis; and creates a strong motivation for this study. Having an evidence-based biblical soul care approach could help bridge the mistrust between the church and those who work in the mental health system. In a collaborative effort on the front lines of mental health, Christ-focused people helpers could focus strictly on peer-to-peer biblical soul care and make disciples, while clinically trained professionals could focus on psychotherapeutic methods, not only to provide therapeutic change, but to also help the whole person. When more of these kinds of studies are accomplished on a consistent basis, the next step would be to share the evidence with mental health professionals and other emotional and soul people helpers. To better comprehend what a peer-to-peer biblical soul care counseling ministry is in the framework of this study, it is important to better understand the historical journey Christian counseling, pastoral counseling, and pastoral care has taken on its slow return back to the church.

**Christian Counseling, Pastoral Counseling and Pastoral Care**

The determination that all counseling should be referred out of the church gave dominance to the field of psychology, psychotherapeutic counseling, and all other aspects of Christian, biblical and pastoral counseling that dissolved in the revolution of psychology (Adams, 1970; Rieff, 1987; Crabb; 2005 MacArthur, 2005; Powlison, 2010; Lambert, 2012). Taking a look at a historical and theological connectedness to psychotherapeutic methodologies can help further clarify the tension between the two and the need for collaboration. First, this next section will provide a clearer understanding of what is meant by Christian counseling compared to pastoral counseling. Then, it will specifically define pastoral counseling and pastoral care and speak to its components.
Christian Counseling

Christian Counseling and Pastoral Counseling are often confused and emphasize a lack of understanding in function between the two, provoking clouded expectations (Malony & Augsburger, 2007; DeYoung, 2017). Christian Counseling, rooted primarily in the method of psychotherapy, is known as a practice provided as a paid service through a counseling center or private practice by a Christian who is professionally educated, credentialed, and often licensed in the state in which the practitioner is providing care (Malony & Augsburger, 2007; McMinn, Staley, Webb & Seegobin, 2010). On the other hand, Pastoral Counseling, rooted primarily in the Holy Bible as its first resource, is more often administered by clergy who are educated and/or credentialed (McMinn, et al, 2010; DeYoung, 2017). Christian Counseling is a resource that a biblically trained peer could use for referral when a sense of mental illness is present. Pastoral counseling is what this study bends more towards yet moves even further to the distinction of pastoral Care. Next, time will be given to understanding the meaning and components of this type of soul care provided in the church.

Pastoral Counseling and Pastoral Care

Pastoral counseling is defined by McMinn, Staley, Webb and Seegobin (2010) as having two distinct definitions, a pastor of a church who has received educational training and offers counseling services to its members or, as a profession of counseling for a person who has credentials both in Christian ministry or counseling, and psychotherapy. Additionally, scholars also state that pastoral counseling is, “the term Christians most often use[d] to describe a religiously based ministry of care, offered by believers and religious leaders; a specialized form of pastoral care best understood as a form of religious ministry offered by a person who is accountable to and representative of a religious community” (Maloney, Mills & Patton, 2005, p.
1350). In other words, Pastoral Counseling is a form of Pastoral Care (Maloney, et al., 2005; McMinn, et al, 2010; Tan 2019).

On the other hand, pastoral care as a stand-alone, is often provided by clergy, or a biblically trained peer who is a member of the church and specifically provides biblical counsel in a church setting, usually for minimal or no fees (Malony & Augsburger, 2007; Cole 2010; DeYoung, 2017). It is this type of soul care, that is specific to this study and presented in the form of the Encourager Program. Pastoral care can also be expressed in two ways – first, directly as soul care, and second, as soul care that takes place in the foreground of what can be referred to as the Christian story (Cole, 2010).

**Soul Care.** The soul is known to be the whole of three parts – the mind, will and emotions (Cole, 2010; Ortberg, 2014; Seacoast Church, 2019). The Greek word *psyche* is literally translated in most English versions of the New Testament to mean soul. *Psyche,* or soul, derives itself from *psychology* or *psychiatry,* meaning the study of the soul (MacArthur, 2005; Sullivan, Pyne, Cheney, Hunt, Haynes & Sullivan, 2014; Ortberg, 2014). The early church used the Greek term *poimenics* – the care and cure of souls – to describe the kind of pastoral work that was the primary job and responsibility of clergy in that time (Cole, 2010; Tan, 2019). Providing clarity to the work of soul care points specifically to offering a structure of healing, sustaining, guiding and reconciling the soul of those who seek care and direction (Cole, 2010), specifically in the context of the church. Dr. Eric L. Johnson (2007), an established professor and promoter of the importance of establishing theology in counseling, notes that soul care serves as a method of “construction or the upbuilding of the soul” (2007, p. 11). In Dr. Johnson’s (2007) thorough discourse, *Foundations of Soul Care,* he extensively discusses what he notes as the core
distinctives of a soul-care model. Those distinctives are noted as being doxological, semiodiscursive, dialogical/trialogical, canonical, and psychological.

First, a doxological expression of soul care refers to the outward expression of praise and glory unto an infinitely beautiful and excellent God; a worship and love to the radiant glory of God (Johnson, 2007). Second, a sufficient soul care model will be semiodiscursive, in other words, it will have meaning (Johnson, 2007). Semiotic meaning is found in signs that point to God such as His creation, or humanity who is made “in the image of God” (Genesis 1:27). Both God’s creation and humanity are created to display his glory (Isaiah 43:7) expressed through signs, utterances and words (Johnson, 2007). Third, soul care has a deeper objective than providing communication to express the glory of God, soul care ought to be dialogical and trialogical, meaning it should be a dialogue between humans to encourage and lift one another up. In the case of an Encourager providing soul care to a Care Seeker, this is an example of two humans connecting to have a dialogue about the situation or crisis the Care Seeker is experiencing. Then, with one ear to the Care Seeker, and one ear to God, the experience becomes a triologue that involves the omnipresence of a Holy God (Johnson, 2007; Seacoast Church, 2019). Fourth, this soul care model should be canonical, a measure, rule or standard (Johnson, 2007). Thus, the Holy Scriptures, the canon, functions as the basic rule for the Christian soul. Finally, and perhaps most challenging for many, Johnson (2007) concludes his soul care model with the idea that it is psychological. As it was noted earlier, psyche is literally translated to soul and means to study the soul (MacArthur, 2005; Johnson, 2007; Sullivan, et. al., 2014; Ortberg, 2014). Thus, psychology becomes a word that finds its origins in the soul and becomes the premise to returning the care of the soul back to the church.
Arguably, this type of soul care can no longer solely be the responsibility of pastors, but rather must extend to those in the church who believe in the tenants of Jesus’ teachings and are trained lay leaders, or trained peers of the church, as referred to in this study (Crabb, 2005; Cole, 2010). Soul care, the care and cure of the soul, is the responsibility of all those who profess faith in Jesus and believe in His teachings from the Holy Bible. Thus, soul care administered through the church becomes the responsibility of the whole rather than just the part, and peers who are actively involved in helping people cope with personal and relational problems learn to provide care from the Bible as it sheds light, “on the nature of human beings and their well-being and improvement” (Johnson, 2007, p16). Additionally, peers providing biblical soul care in the church could then collaborate with mental health professionals in the secular arena, or more pointedly, Christian counselors who have their own professional practices, can begin caring for the whole person. This type of collaboration is then implemented appropriately and becomes the common priority between two people helpers (Collins, 1980; Crabb, 1999; Crabb, 2005; Cole 2010; Tan & Scalise, 2016). The close attention to just the human soul being cared for in the context of community is one aspect that brings distinction to what makes this type of care pastoral. The second aspect is what Cole (2010) refers to as storied care, or the Christian story.

*Soul care that takes place in the foreground of the Christian story.* A person is a soul, and a soul is a person brought to life by the breath of God breathed into the dust that form man (Genesis 2:7; Cole, 2010). And each man, or soul, has a story. Storied care is the care of a soul that has been lived out against the backdrop of evolving stories of those in the Bible, other Christian believers, and the evolving stories of an individual’s life. Specifically, the Christian story is described as being, “The story of God’s creative, transformative, and redemptive acts throughout history, which Christians have most frequently recognized in the history of Israel; the
life, death, and resurrection of Jesus; and the ongoing work of the Holy Spirit” (Cole, 2008, p. 172). Recognizing the soul of a person, a soul that, according to God’s Word, was created to be satisfied in Him and Him alone and bring Him glory (Isaiah 43:7; Johnson, 2007), debatably leads to the importance of this kind of study on an evidence-based, peer-to-peer biblical soul care counseling ministry. Having a group of trained volunteers who would eagerly make proper referrals and partner with appropriate professionals, could potentially bring about a more complete process to a person’s path to healing.

Possibly, most people presenting with mental, emotional or soul problems are not in need of licensed or clinical care that requires fee per hour or insurance coverage, but instead are in need of a safe space to explore the fractions and turmoil within their hearts and souls before God and man, without judgement or criticism (Collins, 1980; Shields & Bredfeldt, 2001; Crabb, 2005). Connecting with a trained church member as a peer, who is willing to come alongside and sit with the soul of a person who is in crisis, allowing for the time needed to work through the presenting circumstance, could theoretically be a source that provides clarity, calm and healing; allowing for a healthy manageable way to live day to day (John 4:26: Crabb 1999; Crabb, 2005; Ortberg, 2014). Rather than the church immediately sending hurting people away for care as a result of not knowing what to do or, legitimately being unqualified for diagnosable issues, it is fair to argue the need for a willingness in God’s people to exist for a desire to provide a safe place for a person seeking help so they can begin their journey of soul healing. Once a person has connected with a trained peer in the church, a proper referral could then be recommended on an as needed basis.

An important point to clarify in offering a referral, is that doing so does not mean an individual is sent away and abandoned, but rather, in this instance, an Encourager would remain
connected and give ongoing support to the Care Seeker and collaborate with a trained clinician who provides the psychological care needed. In other words, the church could be the church caring for the soul, and clinicians could practice as clinicians, caring for mental and neurological disorders in which they were trained to administer. In addition to the integrationists and the separationists (Shields & Bredfelt, 2001; Sites, Garzon, Milacci & Boothe, 2009), this study attempts to fill a gap where less attention has been given to collaborationists (Sullivan, et al., 2013) who are willing to provide pure, peer-to-peer biblical soul care in the context of the church, and who will eagerly collaborate with those who are clinically trained in the secular mental health field. A change is notable as occurring among those in the mental health field as they begin to recognize and acknowledge faith as an important role in the healing of heart, mind and soul (Sullivan, et al., 2013).

**Conclusion**

The danger of continuing in the current ambiguity surrounding Christian counseling, pastoral counseling, and pastoral care, could only accomplish what Maloney and Augsburger (2007) noted as a thoughtless eclecticism. Meaning, helpers, whether properly equipped or not, would sit with someone in need of counseling and care and attempt to help them with whatever method or technique comes to mind. Instead, trained church members could provide the right kind of soul care through a deep conviction grounded in empirically based theory, and a well thought through spiritual and professional identity while collaborating with secular professionals. Both types of helpers are needed – the clinician who is well versed, thoroughly educated and credentialed in their specific area of expertise, and the pastoral caregiver or peer soul caregiver, who is well versed in God’s Word, and knowledgeable about his program methodology of choice.
The idea of collaboration as another viable solution to helping someone could possibly bridge the gap between clergy and mental health professionals when more church program studies of this kind are consistently performed to provide scientific validity. Doing so, could authenticate a peer-to-peer methodology such as the Encourager Program that helps discover impact on constructs such as personal well-being, spiritual well-being and church engagement. The notion of collaboration could potentially provide the needed foundational framework needed to help build on the limited amount of present research currently available in the way of church programs.

**A Peer-to-Peer Methodology**

In the first two chapters entitled “Introduction” and Literature Review”, there has been consistent mention of the Encourager Program being a type of program intervention, as well as a type of peer-to-peer methodology offered in the context of the church. In this study, the term “peer” replaces “lay” or “laity” to describe a care giver who provides biblical counseling, or biblical soul care, offered in the church; however, the two share the same definition. Collins (1980) defines lay counselors as helpers who may not be trained, but who actively involve themselves in helping people cope with personal and relational problems. The main difference between pastoral counseling and pastoral care, or peer-to-peer biblical soul care, is the level of training and credentials the care giver has obtained.

To bring greater understanding to this concept of a peer-to-peer methodology, the following section will first, offer a biblical support to the peer-to-peer concept. Next, there will be a brief mention of a few of the peer-to-peer biblical soul care programs provided in a church setting, whether they are offered in a group or one-on-one setting. Additionally, there are five constructs identified in this study to help determine if peer-to-peer biblical soul care could have
any kind of impact on personal well-being, spiritual well-being and church engagement. Starting with the two independent constructs, there is a brief explanation on the role of peers as Encouragers, followed by the Encourager Program and its components. Then, a section on the three dependent constructs, two of which are subjective, personal well-being, spiritual well-being and a third, church engagement. These dependent constructs are explored for how they are impacted by a peer-to-peer biblical soul care program, when administered specifically in the church.

**Biblical Support for a Peer-to-Peer Biblical Soul Care Ministry**

1 Thessalonians is a pastoral letter written to the church of Thessalonica and established by Paul during his second missionary journey (Acts 17:1-15; Wiersbe, 1989). The Apostle Paul begins his letter to the Thessalonians as encouragement and affirmation for their strong faith and good reputation (I Thessalonians 1). He continues in chapters 2-4, reminding them of the relationship between one another, challenging them to please God in their daily living, and to remember the hope of the resurrection. In the first part of chapter 5, Paul speaks of the assurance Christians have for the return of Christ and the dead being raised to life (vv. 5-11). Paul then asks the brothers in the church to respect the leaders among them and to care for the needy, making care for the needy a matter of all believers in the church (vv. 12-22) (Wiersbe, 1989; Hamp, 2017). Frank Minirth (1990) directly addressed 1 Thessalonians 5:14 in his written work, *Christian Psychiatry*. In it, he stipulates directives from the Scripture as to how believers should care for others, indicating supporting evidence for a peer-to-peer biblical soul care counseling ministry in the church. Tan and Scalise (2016) quote from Minirth’s work, “And we urge (parakaleo) you, brothers and sisters, warn (noutheteo) those who are idle and disruptive, encourage (paramutheomai) the disheartened, help (antichomai) the weak, be patient
(makrothumeo) with everyone. If translated in English word for word, the passage would read, and we admonish you, brothers and sisters, encourage/console/comfort those who are idle and disruptive, console/comfort the disheartened, assist, the weak, be longsuffering with everyone” (Tan and Scalise, 2016, p. 33). In the opinion of this author, Minirth’s definition as stated above describes the Encourager Program perfectly and shows how a structured peer-to-peer biblical soul care methodology could effectively contribute to caring for the more than 85% (Stanford, 2014; Stetzer, 2019) who seek care in the church. In addition, there are many other types of peer-to-peer biblical soul care church programs that are offered in the context of a church and should be considered for future, rigorous testing for additional scientific validity. A few are mentioned here to acknowledge the efforts already active in caring for those who seek care at Hope Church in Las Vegas, NV.

**Different types of Peer-to-Peer Biblical Soul Care Programs**

While numerous types of church programs are offered in a group and one-on-one setting, minimal, if any, dedicated research has been provided to demonstrate efficacy with quantitative outcomes. It is the strong belief of this researcher that the lack of evidence hinders the church in being respected and considered a reliable resource with properly trained care givers as it pertains to providing peer-to-peer biblical soul care. A succinct look at some of the group and one-on-one biblical soul care interventions, will hopefully provoke further exploration and research that could provide substantial efficacy for future review.

**Types of Group Care Church Programs.** One example is Church Initiative, a non-denominational, non-profit organization that equips and mobilizes teams of peers to provide care in a church-based group setting (Church Initiative (CI), 2020). The organization strategically designs video-based curriculums that are directly administered in group settings to those who are
experiencing life crises by trained peers who are members of a church (CI, 2020). Church Initiative has equipped more than 22,000 churches to provide specific care for grief through GriefShare, divorce through DivorceCare and DivorceCare for Kids, and for those who are in the mode of single parenting through Single & Parenting (CI, 2020). All the sub ministry curriculums are designed in a 13-week format and are meant to be offered specifically in the environment of a church, administered by peers who often have themselves experienced a life crisis and gone through the applicable support program.

These church support programs are designed around three strategies – care and comfort for the hurting people, outreach to the community, and equipped and trained peer ministry teams. They are an example of the kind of peer-to-peer biblical soul care discussed in this study and are emulated in the Encourager Program. These types of programs are in need of rigorous, consistent scientific research, in order to implement a strong design that could withstand scientific criticisms over time. Additionally, the same type of research is needed for one-on-one church programs which this study is implementing.

**Types of One-on-One Church Programs.** In addition to the type of group care discussed above, there are also church programs that provide one-on-one biblical soul care. Two examples of a one-on-one methodology used in the context of the church through its peers are Stephen Ministries and the Encourager Program. Stephen Ministries’ Scriptural reference is, “Bear one another’s burdens, and in this way, you will fulfill the law of Christ” (Galatians 6:2; Stephen Ministries (SM), 2020). Much like Church Initiative (2020), Stephen Ministries equip church peers to administer high-quality care, but in a one-on-one setting, and to those experiencing life difficulties. The organization trains peers to provide care to those with a variety of needs such as grief, divorce, unemployment, hospitalization, a spiritual crisis, financial stress, infertility,
rehabilitation after an injury, terminal illness, relocation, and long-term disability to name a few (SM, 2020). There are more than 13,000 churches enrolled in this ministry and collectively they provide more than 4 million hours of one-on-one care (SM, 2020). To date, although there are articles and testimonies providing written witnesses of how effective Stephen Ministries are in the life of a Care Seeker, there is no direct quantitative research accomplished to show efficacy. The Encourager Program provides care in the same way and also has no scientific data to support its usefulness, thus the significance of this study.

The Encourager Program as a Comparable Peer-to-Peer Option

This section describes what the Encourager Program is, the different components of the program, which include the details of each of the three sessions, and the positions of counselors as Encouragers and clients as Care Seekers. First, the Encourager Program was created by Katie Walter (2018), the founder and creator of the program, and was produced out of Seacoast Church in South Carolina (Seacoast, 2018). After some time, the program was made duplicatable through training videos and curriculum for other churches to implement. The 3-session program is administered by an Encourager, a trained peer, to a person seeking care through the church, referred to as a Care Seeker. The Encourager Program for this study is administered in the LIFE Center, a peer-to-peer biblical soul care ministry at Hope Church. An Encourager is a peer and, in the ministry of the LIFE Center, is required to be a member of the church and is expected to be a believer in the teachings of Jesus.

Prior to becoming an Encourager who meets with Care Seekers, the Encourager is required to attend Foundations Training (Appendix A), a 5-week training that provides the necessary knowledge and tools to offer biblical soul care consistent with the Encourager Program. Once completed, the Encourager is ready to meet a Care Seeker for three sessions,
typically occurring in a once a week, one-hour session format. The three sessions consist of the Care Seeker having the opportunity to tell their story, the Encourager speaking truth from God’s Word into the situation described by the Care Seeker, concluded by the final session where the Encourager and Care Seeker will together, determine what the next best step is. A more detailed description of each session follows.

Session 1: Story. In session one, the Encourager exercises unconditional positive regard while the Care Seeker has uninterrupted time to tell their story. A Care Seeker’s story is usually a circumstance that has caused them a higher level of distress than they are accustomed to handling and leads him or her to contact the church. In that time, the Encourager is actively listening (Petersen, 2007), without interruption and assuring the Care Seeker that he is not alone. At the end of the first session, the Encourager prays with the Care Seeker, provides encouragement and assurance that he will pray during the upcoming week, and schedules session two, the next appointment.

Session 2: Truth. Encouragers commit to pray for the Care Seeker in between sessions one and two and return with a scripture from God’s Word that is encouraging and pertinent to the situation previously discussed in session one. If applicable, the Encourager could share an example of how God’s Word helped in a similar situation in their own life. The Encourager helps the Care Seeker understand what God may be saying through His Word and often provides homework such as memorizing scripture or reading a devotional that is related to the situation that he or she is experiencing. At the end of session two, the Encourager again closes the session in prayer, assures the Care Seeker of continued prayer and this time, invites the Care Seeker to also pray, asking God what He might have as a next step in his or her life. A time is scheduled to
meet for the third session, understanding that the next appointment will conclude their time together.

**Session 3: Next Step.** Ideally, the Care Seeker and Encourager have both spent time praying and seeking God for the next step and upon meeting for the third and final session, come to agreement as to what is the best next step for continued healing. The Encourager is trained to not prescribe the next step for the Care Seeker, but rather facilitate the discussion of what the Care Seeker is discerning as their best next step. Hope Church’s mission is to connect people to live the life of a Jesus follower (Hope, 2021), and in the context of the LIFE Center where the study took place, a next step for Care Seekers could be connecting in a small group, a support group such as GriefShare or DivorceCare, meeting with a trained biblical counselor at the church for more intensive biblical counseling, a solution-focused short-term methodology, or serving in the church. The goal is to connect the Care Seeker into the life of the community where further healing and real-life change could occur; not because someone is telling a person what should be done in their life, but through a supportive process of creating a common solution together (Kollar, 2011; Crabb, 2005). In the next section, the above-mentioned peer-to-peer methodology provided through the intervention of the Encourager program analyzes five constructs to determine efficacy – Encouragers, Care Seekers, personal well-being, spiritual well-being and church engagement.

**Constructs**

This body of research consists of five constructs, two independent and three dependent constructs. The first independent variable is the Encourager Program, the intervention provided to the Care Seeker as a methodology of biblical soul care. The second independent variable is the Encourager, identified in this study as a peer, thus the reason for the reference to peer-to-peer
biblical soul care. Care Seeker is consistent with what a clinician refers to as a client and is a peer of the Encourager. The three dependent variables tested in this study for statistical significance are personal well-being, spiritual well-being and church engagement. The following will discuss each construct individually.

**Peers as Encouragers.** Encouragers are peers to those seeking care in the church. In this study, lay counselors and peer counselors are used interchangeably. As described earlier, and consistent with the definition of an Encourager, peer counselors are members of a local church who believe the teachings of Jesus to be true and attempt to help another person in distress deal more effectively with the stresses of life (Collins, 1980; Garzon & Tilley, 2009) as directed by the Word of God. An Encourager is a volunteer of the LIFE Center, a ministry in Hope Church. Those interested in becoming an Encourager are required to attend the LIFE Center Foundations training (Appendix A), a 5-week training that incorporates the Encourager training and an overview of Larry Crabb’s (2005) work, *Connecting*.

In another book written by Dr. Crabb (1997), the model he proposes for peer counseling in the church has three levels. Level one is counseling by encouragement – a form of counseling every member of church could provide by loving one another, bearing one another’s burdens and praying for one another. Level two is counseling by exhortation – a type of counseling that becomes more selective to those who are a group of trained believers such as Encouragers. Level three is counseling by enlightenment – another type of counseling provided in the church by mature members given more extensive training such as the one-year Biblical Counseling training (Appendix B) offered to Encouragers who have a sense of being called into a deeper care for the souls of others and becoming biblical counselors in the church (Collins, 1980; Crabb, 1997; Wagner, 2012). In its simplest form pure, peer-to-peer biblical soul care is provided by a brother
or sister in Christ, who comes alongside a person in crisis or needing direction and encourages a person seeking care through a crisis (Tan & Scalise, 2016).

**The Encourager Program.** Biblical counseling occurs between two individuals who attempt to establish a caring relationship where the care giver, in this case an Encourager, attempts to help the Care Seeker more effectively handle adverse circumstances (Collins, 1980). With that understanding in mind, Collins (1980) lays out the goals of peer-to-peer biblical soul care that finds alignment with the steps of the Encourager Program: story, truth and next step.

**Clarify problems and explore and express feelings.** When a Care Seeker meets with an Encourager for the first time, this is the opportunity to tell their story, clarify the presenting problem(s) that has caused them to seek care and to explore and express their feelings, whatever those feelings may be. That expression of feelings is accomplished in a safe space without judgement or criticism. Examples of this might be a Care Seeker presenting with a story about their anger issues and the inability to control outbursts in certain settings or, a wife whose husband has committed infidelity and she wants to forgive him and make the marriage work.

**Coping with stress and confronting Care Seekers with their sinful and self-defeating thoughts and/or actions.** In the second session between the Encourager and Care Seeker, the Encourager has been trained to take the responsibility of praying for and seeking God on behalf the Care Seeker for words of truth from the Holy Bible, an example of a trialogical distinctive mentioned earlier as discussed by Johnson (2007). As stated previously in the chapter, Encourager literally means to impart courage into the life of a Care Seeker to help them cope with the stressors in life. Scripture also calls upon Christians to exhort one another on a daily basis to avoid being hardened by the deceitfulness of sin (Hebrews 3:13). Thus, an Encourager is trained to confront and speak Biblical correction in truth and in love, into whatever sin, self-
defeating thoughts, and actions the Care Seeker presents with in order to help discover a fresh willingness to live according to biblical teaching (Collins, 1980).

Using the example of anger given above, an Encourager may share an example of someone in the Bible who also experienced anger, in an effort to help the Care Seeker know they are not alone. Moses is a good example of someone who expressed anger. In Numbers 20, the Israelites were grumbling against Moses and Aaron, Moses’ brother, because they had no water (v. 2). God asked Moses to speak to the rock and water would come forth (v. 8), but in frustration and anger with the people for complaining, Moses struck the rock twice (v. 11). A story like this could also show consequences for outbursts of anger as Moses did not get to lead the Israelites into the promised land God was taking them to live out their freedom (v. 12). Anger can inhibit freedom, and this teaching could be shared with the Care Seeker, not to admonish, or immediately instruct, but to again, show they are not alone, and that God understands.

**Finding freedom from spiritual, psychological, and interpersonal conflicts; and developing self-acceptance and God-awareness.** The third and final session between the Encourager and Care Seeker is meant to help determine the best next step for the Care Seeker to take in order to continue on in healing and life change in the context of community (Crabb, 2005). The Encourager helps the Care Seeker find the freedom offered in the words of Scripture, with the goal of the Care Seeker developing a healthy sense of self-acceptance and God-awareness (Collins, 1980). As needed, further freedom could come through proper referrals when psychological or interpersonal conflicts (1980) require clinical care. Again, using the example of the Care Seeker presenting with anger, this could look like a determination to seek further biblical counseling. In the setting of the LIFE Center at Hope Church, there are trained biblical counselors the Care Seeker could connect with, or based on the severity of the anger, a
proper referral could be recommended. Another next best step, if the Care Seeker has been relieved by simply being able to tell their story, and hear truth from God’s word, is to connect them in small group in order to receive the type of healing community can provide.

Although the Encourager and the Encourager Program are the two independent variables in this analysis, it is the Care Seeker who is being observed for any modification in personal well-being, spiritual well-being and church engagement, the three dependent variables, as a result of the Encourager Program. Next, is a more detailed look at the three dependent variables.

**Personal well-being.** Personal well-being, a part of the overall construct of quality-of-life measures, is broad in its measure and is a construct that can be conceptualized in a variety of ways (Tomyn & Cummins, 2010). In a study on the Duke Health Profile, an instrument with measures that has been developed over the last 35 plus years (Duke University, 2020), personal well-being in this scale identifies six health measures – physical, mental, social, general, perceived health, and self-esteem, and four dysfunction measures – anxiety, depression, pain, and disability (Parkerson, Broadhead, & Chiu-Kit, 1990). In this study, personal well-being pertains to the anxiety and depression dysfunction measures and in a self-report method by the Care Seeker, conceptualizes the impact a peer-to-peer methodology, specifically the Encourager Program, could have on personal well-being.

Literature provides evidence that depression and anxiety are likely the two highest mental illnesses to show up in the general population and are the consequences of many of the crisis’s individuals face in day-to-day life (Kroenke, Baye, Lourents, 2019). When an individual presents with two or more illnesses, the condition is known as comorbidity (American Psychiatric Association, 2013; Salcedo, 2018). Depression and anxiety are one of the top comorbid diagnoses, with some research showing that 60% of those diagnosed with anxiety will also
present symptoms of depression (Salcedo, 2018). The year 2020 presented a global pandemic from a virus that spread world-wide. As reported by the Centers for Disease Control and Prevention (CDC), as of August 2020, the Coronavirus (COVID-19) has produced more than 21 million confirmed cases and nearly 800,000 deaths world-wide with no real end in sight (Google News, 2020). In the United States, there are more than 5 million confirmed cases and nearly 170,000 deaths as of August 2020, with a steady climb in stress, anxiety and depression (Google News, 2020; Safai, 2020). Already stated, the church is considered a front-line resource for those in crisis. With this increase in affective disorders, comes an increase in the number of those affected who will contact the church first for help. To be sure, if even a fraction of the 5 million confirmed COVID-19 cases experienced depression and anxiety, the previously mentioned 85% who contact the church first, would produce a tsunami like effect of people who are suffering that the church must be prepared to handle. In order to properly interact with those whose personal well-being could potentially be on the decline, the church must have trained peers ready to provide care and offer proper referrals. This body of research is even more critical in light of that specific need so that more direct biblical soul care can be provided in a timely and efficient manner.

**Spiritual well-being.** Spiritual well-being is also a widely used construct that has been well studied in various settings. One way to operationalize spiritual well-being is through an understanding of spiritual fortitude, espousing the ability to endure adversity with virtue and prosocial activity regardless of the outcome (Hall & Edwards, 2002; McElroy-Heltzel, Van Tongeren, Gazaway, Ordaz, Davis, Hook, Davis & Aten, 2018; Van Tongeren, Aten, McElroy, Davis, Davis, Hook, 2019). McElroy-Heltzel, et al. (2018) make a succinct distinction between fortitude, resilience and grit. Being resilient often has to do with the ability to bounce back after
a crisis, whereas having grit enables a person to endure and pursue a specific goal, often in the midst of a crisis (Brown, 2015; David, 2016; Duckworth; 2016; McElroy-Heltzel, et al., 2018; Van Tongeren, et al., 2019). Conversely, fortitude facilitates resilience and endures regardless of the goal (Van Tongeren, 2019).

Again, a great deal of literature exists and supports a positive impact of spiritual well-being in a variety of settings during stressful times or a crisis (Hall & Edwards, 2002; Jafari, Dehshiri, Eskandari, Najafi, Heshmati, & Hoseinifar, 2010; Unterrainer, Ladenhauf, Moazedi, Wallner-Liebmann, 2010; Velasco-Gonzalez & Rioux, 2013; Abu-Raiya, Pargament, & Krause, 2016; Salwen, Underwood, Dy-Liacco & Arveson, 2017; Van Tongeren, 2019). This study brings understanding to spiritual well-being in a different way as it is being tested through a peer-to-peer methodology specifically executed in the church.

**Church Engagement.** Church engagement is a pilot measure being conceptualized in this study to mean attendance and extent of involvement in church community, specifically in the areas of serving, joining a small group, or going on a mission trip. A previous literature review revealed a loose correlation with consistency in church activity and attendance (Mueller, P.S., Plevak, D.J., Rummans, T.A., 2001; Koenig, 2012; Peteet & Balboni, 2017; VanderWeele, 2017). More than just a moralistic measure of well-being, church engagement provides a better understanding of the relational thrust the Bible speaks to as it relates to encouragement that comes from within community (Crabb, 1999; Homan, 2015). In the church, one can receive spiritual direction and friendship only through spiritual community and engagement in the church (Crabb, 1999; Homan, 2015). In addition to the care provided by licensed professionals, what Crabb (1999) refers to as a “healing community” is offered here as a viable option to caring for those in crisis.
This can only come through the church, thus supports the importance of this study as a way to begin providing quantitative outcomes to qualitative measures.

**Conclusion**

In the previous sections of this literature review, a broad, historical overview of mental health during the 19th and 20th centuries was presented. Then, we looked at the state of mental health in the 21st century. Next, we looked at a biblical peer-to-peer methodology known as the Encourager Program, followed by a look at the five constructs expended in this study that were analyzed and intended to demonstrate quantitative outcomes. A peer-to-peer biblical soul care counseling ministry could be developed in the context of any church and given structure to train peers on how to effectively come alongside those who seek care through the church. Dr. Larry Crabb (1999), a licensed psychologist, is another huge proponent of peers who provide the needed healing to those who are suffering and allows for greater life change in spiritual community. Dr. Crabb (1999) explains that true communities are those with God at the center, where humble and wise men and women learn to shepherd, rather than purposing to fix those who are hurting.

In conclusion, the state in which this type of literature finds itself demonstrates the urgent need for more studies like this and for trained volunteers, who offer peer-to-peer biblical soul care in the context of the church. Specifically, through the Encourager Program, as a part of the solution to the growing mental health crisis. Offering this kind of caring ministry at no charge, with a resolve to collaborate with mental health professionals will allow for an expansion to the mental health care system currently provided. At a minimum, this study could initiate honest discussions around the process of directing a person in crisis to other resources that might help them overcome the struggles they are experiencing. Especially when a person’s crisis goes
beyond the competency of a trained peer in the church. Those who are called (Wagner, 2012) to provide biblical soul care in the church could lead through the Word of God, and through the power of prayer, working to help those who are suffering in a primarily discipleship-focused, biblical soul care methodology.

If reliable church program studies such as this one becomes consistent in occurrence, it could potentially help reduce the stigma that plagues those with mental illness and lessen the number of people suffering alone (Stetzer, 2016). Peer biblical soul care givers could seek to collaborate, as needed, with mental health clinicians and licensed professionals who are established, rightfully so, to receive monetary compensation. Rather than add to the plethora of evidence-based secular therapeutic techniques and spiritual and psychotherapy integrative methods, this study proposes a concentrated look at peer-to-peer biblical soul care provided through the intervention of the Encourager Program in the context of the church. The current study then becomes a resource for biblical soul care givers and counselors to the heart, mind and soul. Additionally, by providing rigorous, scientific validity to peer-to-peer biblical soul care counseling ministries, potentially proving similar efficacy with secular counseling and psychotherapies, this study moves church programs into the mental health conversation and, into being a viable resource.
CHAPTER THREE: METHODS

Overview

As has been stated in the previous two chapters, the intention of this investigation was to discover what impact the Encourager Program would have on personal well-being, spiritual well-being and church engagement. Moreover, the current study was put forth to add to the vast volume of research already applied toward personal and spiritual well-being when measured in many other settings. This research specifically adds the aspect of a church setting, which does not have the same volume of applied research, if any. As well, this analysis brought attention to the Encourager Program, a church program that currently has no scientific evidence to support its efficacy, and its impact on personal and spiritual well-being, and church engagement specifically, as it relates to serving in the church, joining a small group, or going on a mission trip. As has been previously stated, the Encourager Program is a three-session program developed out of Seacoast Church (2020) in South Carolina and was adopted in the LIFE Center at Hope Church in Las Vegas, NV. The program’s training was incorporated into the Foundations Training (Appendix A) required for all volunteers who serve in the LIFE Center. The design and methodology implemented to discover what impact the Encourager Program had on personal well-being, spiritual well-being and church engagement, was a quantitative, quasi-experimental pretest/posttest research design.

First in this chapter, a more detailed description of the quasi-experimental design is provided, along with a concise rationale to support the researcher’s choice for this type of design used. Second, the research questions are listed, followed by the hypotheses that were tested in the third section. Fourth, a description of who the participants were, and the setting in which this study was conducted is considered. Fifth, the instruments, the Intake and Feedback forms used to
test dependent variable outcomes are described in detail. Sixth, the procedures implemented, and the methodology used for data collection are explained. Next, a data analysis is provided for the outcomes from the hypotheses that were tested. Finally, a conclusion is provided that expresses the significance of this type of study, and the urgent need for continuous future research to be conducted on church programs.

**Design**

The design of this study is a quantitative, quasi-experimental, pretest-posttest model that was implemented over an eight-week period. As mentioned earlier in Chapter 1, past research on personal well-being and spiritual well-being has shown a statistically significant difference in various settings with other groups of participants (Jafari, Dehshiri, Eskandari, Najafi, Heshmati, & Hoseinifar, 2010; Unterrainer, Ladenhauft, Moazedi, Wallner-Liebmann, 2010; Velasco-Gonzalez & Rioux, 2013; Abu-Raiya, Pargament, & Krause, 2016; Salwen, Underwood, Dy-Liacco & Arveson, 2017; Van Tongeren, 2019); however, the same two dependent variables do not have the equivalent amount of applied research specifically in a church setting through a quasi or experimental design. The lack of empirical outcomes on biblical soul care offered from within the context of the church, emphasizing the impact this type of methodology could have on personal well-being, spiritual well-being, and church engagement in a church setting, provided the strong rationale for this type of investigation. And, as a result of the impact the global pandemic had on sample size, shaped this study to become more of a pilot, exploratory project that employed the quasi-experimental methodology.

To discover the impact the independent variable had on the dependent variables, a pre, mid and posttest method was implemented within the quasi-experimental design to determine if the dependent variables quantitatively increased at mid and posttest when compared to pretest,
after intervention. Typically, quantitative research seeks to demonstrate a facts-based approach (Barnham, 2015; Hernández, 2015) with numerical values. This is the goal of this study, to add numerical results for peer-to-peer biblical soul care that could demonstrate a statistically significant difference. While a quasi-experimental design does not provide all the features of a true, experimental approach, such as having randomly assigned participants or a control group, this particular design was determined to be the most effective choice because of its pretest/posttest nature, and how it makes use of an intervention to determine statistically significant differences between the means of at least three levels of a within-subjects factor (Warner, 2013; Bärnighausen, Rottingen, Rockers, Shemilt, & Tugwell, 2017; Laerd Statistics, 2021). The quantitative nature of this research, compared to a qualitative nature, could further present empirically based evidence that could withstand the rigors of scientific testing. While quantitative and qualitative measures both have advantages and limitations, in its simplest explanation, a quantitative focus was chosen for this particular study due to the supposed likelihood of having a large sample size, as well as results providing impartiality and accuracy (Charlwood, Forde, Grugulis, Hardy, Kirkpatrick, MacKenzie, & Stuart, 2014; McCleod, 2019). Whereas qualitative research is known to bend more towards a descriptive nature, and an observed but not measured phenomenon (Bauer, 2019; McLeod, 2019; Anpar Research, 2020). Additionally, this study means to provide inspiration for future researchers to continue arduous exploration into whether or not these particular constructs could be impacted by a peer-to-peer biblical soul care methodology, specifically administered in a church setting. A quasi-experimental, pretest/posttest design allows for quantitative outcomes and provides the rationale for its use on the constructs mentioned, measured in a church setting. The gap in literature
around this type of design for scientific outcomes from a church setting help shape the research questions and hypotheses.

**Research Questions**

Based on past research from other scholars in regard to church community, the author presumes that church community can in fact make a difference in a person’s self-reported personal and spiritual life when they are experiencing challenging circumstances and seek care through the church (Abraham, 2014; Averbeck, 2008; Crabb, 1999; Crabb, 2005). Theoretically, meeting with clergy or trained parishioners, referred to as peers in this report, could indeed help a person find a certain degree of healing, as well as bring attention to an individual recognizing their need for a healing community (Abraham, 2014; Crabb, 1997; Crabb, 1999; Greene-McCreight, 2006). Consistent with the rationale for this study to put forth quantitative measures, the author’s opinion that biblical soul care and church community could make a statistically significant difference, provided the basis in which the research questions were developed. The research questions were proposed to help bring forth empirical evidence that could potentially demonstrate whether or not personal well-being, spiritual well-being and church engagement were positively impacted by a peer-to-peer biblical soul care program. Thus, the research questions were as follows:

**RQ1:** Is there an increase in personal well-being after session 2 (mid) compared to pretest, when a Care Seeker participates in the Encourager Program?

**RQ2:** Is there an increase in personal well-being after session 3 (post) compared to pretest, when a Care Seeker participates in the Encourager Program?

**RQ3:** Is there an increase in spiritual well-being after session 2 (mid) compared to pretest, when a Care Seeker participates in the Encourager Program?
RQ4: Is there an increase in spiritual well-being after session 3 (post) compared to pretest, when a Care Seeker participates in the Encourager Program?

RQ5: Is there a difference in church engagement after session 2 (mid) compared to pretest, when a Care Seeker participates in the Encourager Program?

RQ6: Is there a difference in church engagement after session 3 (post) compared to pretest, when a Care Seeker participates in the Encourager Program?

From the six research questions presented for this investigation, six hypotheses were developed.

**Hypotheses**

At least three assumptions undergird this study – first, a church program that provides one-on-one biblical soul care could bring about a healthy personal well-being. Second, the same church program could bring about a healthy spiritual well-being; and third, as a result of the church program, a Care Seeker would remain, become engaged in, or increase involvement in church community. These assumptions led to the following alternate hypotheses:

Hₐ₁: When a Care Seeker participates in the Encourager Program, there is an increase in personal well-being after session 2 (mid) compared to pretest.

Hₐ₂: When a Care Seeker participates in the Encourager Program, there is an increase in personal well-being after session 3 (post) compared to pretest.

Hₐ₃: When a Care Seeker participates in the Encourager Program, there is an increase in spiritual well-being after session 2 (mid) compared to pretest.

Hₐ₄: When a Care Seeker participates in the Encourager Program, there is increase in spiritual well-being after session 3 (post) compared to pretest.

Hₐ₅: When a Care Seeker participates in the Encourager Program, a Care Seeker will remain, become involved in, or increase church engagement after session 2 (mid).
**Ha6**: When a Care Seeker participates in the Encourager Program, a Care Seeker will remain, become involved in, or increase church engagement after session 3 (post).

The dependent variables, personal well-being, spiritual well-being, and church engagement were measured between three levels of a within-subjects factor, pretest, mid-test after session two, and posttest, after session three. Specifically having the midtest aspect in the design of the study was due to the times some Care Seekers would, undoubtedly be unable to complete all three sessions. Incompletion of three sessions usually fell to uncontrollable circumstances that could occur either in the life of the Care Seeker or the Encourager. For that reason, an eight-week time period was set for the Encourager and Care Seeker to meet for three sessions. Since some participants would not complete all three sessions, personal well-being, spiritual well-being and church engagement were tested at pre (before session one), mid (after session two) and post (after session three) Encourager sessions. The possibility for data collection to only come from pre and midtest results, could potentially bring about a smaller sample size that would not be fully representative of the larger population at Hope Church or in the Las Vegas Valley. As a pilot study on the Encourager Program, this research sought then to lay the groundwork for more extensive studies to be conducted using this type of design and methodology in the future. Next, is a discussion about the participants and a description of the setting in which this study was conducted.

**Participants and Setting**

**Participants**

Participants in this study, referred to as Care Seekers, were obtained through convenience sampling from those who self-initiated contact to the LIFE Center for biblical counseling and soul care. Care Seekers came from those who attended Hope Church in Las Vegas, NV, a
congregation of nearly 4,000 average attendance on Sundays at the time this study came to its end. Participants also came from the surrounding community of Las Vegas and Henderson, NV through word of mouth, by way of the church’s mobile application, the website at www.hopechurchlv.com, social media platforms such as Facebook, or Instagram and Twitter. Participants would contact the LIFE Center via phone call, email or an online ‘Contact Me’ Form. Low costs and ease of access to participants due to self-initiated contact to the LIFE Center were reasons why a convenience sample was practical for this design (Warner, 2013).

To answer the research questions and test the hypotheses previously presented, a power analysis indicated the minimum sample size needed was $N = 56$ in order to achieve a .50 effect size with a confidence interval (CI) of .95 and a Type I error rate of $\alpha = .05$ (Faul, Erdfelder, Buchner & Lang, 2009). As a result of a global pandemic discussed more in depth in chapter 4, the researcher and faculty determined to close data collection for this investigation after six months, well after the proposed 8 weeks to conclude this study in an effort to obtain power analysis, and a smaller sample size of $N = 5$, consisting of 100% female, ranging in age from 34-65+ years, was analyzed. In light of this consequence, outcomes reported caused an increase in a Type I error and more or less dissolved effect size.

**Setting**

Las Vegas Valley is a major metropolitan area in the southern part of the state of Nevada. The LIFE Center, a ministry within Hope Church, is situated in the southeastern part of the valley. Las Vegas primarily consists of two major cities, the city of Las Vegas, which has a population of 651,319 and Henderson, with a population of 320,189 as of July 1, 2019 (United States Census Bureau, accessed 2021). The convenience sample came from this population and participants were referred to as Care Seekers upon making contact with the LIFE Center. The
LIFE Center is a Biblical Counseling/Discipleship Ministry, and since the Fall of 2012 has provided ministry in four main areas: Biblical Counseling, Care Groups: GriefShare, DivorceCare, Financial Peace University, STEPS; Bereavement: Funerals and Memorials, and the addition of the Encourager Program in 2015. The LIFE Center employs two Hope staff members, the Director, and an Administrative Assistant. Additionally, as of the time of this research, approximately 30 trained volunteers served in the whole of LIFE Center ministry. At the time of this study, 18 of the 30 trained volunteers were Encouragers and were available to be assigned a Care Seeker. Gender pairing, male to male and female to female, a process already in place prior to this study, became a part of this study’s design due to reason’s explained later in this chapter. Assignments came to Encouragers after being trained through Foundations Training (Appendix A), a five-week training conducted on site at Hope Church. The 5-week training consists of the Encourager Program training, a five-session video curriculum developed by Seacoast Church (2020) during the first three weeks, and an overview of overview of Larry Crabb’s (2005) written work titled, Connecting the last two weeks. The specifics of the process and how the pairings were made are described later in the “Procedures” section of this chapter.

Intentionally, and to support the rationale and design of this research, the LIFE Center does not have licensed clinicians who serve or work in the LIFE Center. Not having clinicians allowed for the ministry to be positioned as a pure, peer-to-peer biblical soul care ministry that was strictly volunteer based.

Continuing with the rationale for this research, Encouragers and Care Seekers met either in the LIFE Center office on Hope Church’s campus or, when appropriate, or in another agreed upon location, e.g., a local Starbucks, opposed to meeting in clinical settings. As previously mentioned, gender pairing was a part of the methodology used to connect Encouragers and Care
Seekers. It is the protocol and intention of the LIFE Center to connect a female Encourager to a female Care Seeker and a male Encourager to a male Care Seeker. Although there is little evidence to support whether or not matching genders makes a difference in outcomes, there is some evidence showing that gender relevance can create a significantly higher therapeutic alliance satisfaction in female pairing than in male pairing (Staczan, Schmuecker, Koehler, Berglar, Crameri, Wyl, Koemeda-Lutz, Schulthess & Tschuschke, 2017; Norcross & Lambert, 2019). While this evidence provides minimal support to the rationale for gender pairing in the Encourager Program, the primary reason for doing so is the expectation and standard set by the Senior Pastors of Hope Church and the Director of the LIFE Center. As well, a sensitivity to avoid any temptation toward sexual immorality or misconduct, and to avoid all appearances of inappropriateness (I Thessalonians 5:22) while peer-to-peer soul biblical care is being extended in a church setting, is a matter of significant biblical importance to senior leadership at Hope Church and in the LIFE Center. Although this pairing does not provide for pure random assignment consistent with a true experimental design, it provides further support for the need to have more studies such as this type of design as a foundation to improve upon, making it more of an experimental design with random assignment and a control group. Those limitations will be discussed further in chapter 5. Next is a look at the instruments used to measure the dependent variables put forth in this study.

**Instrumentation**

In order to measure personal well-being, spiritual well-being and church engagement pre, mid and posttest, the 7-point subscale in the Duke Health Profile (Parkerson, et al, 1990), the 20-point Spiritual Well-Being Likert Scale (Ellison & Paloutzian, 1982), and two questions created by the Director on church engagement were included in the Intake Form (pretest), and a
Feedback Form sent to the Care Seeker via email or text for mid and posttest data. The Intake Form was completed prior to session one when a Care Seeker requested care and created a secure, personal account through Biblicare© (2016), a web-based database specifically designed for use in a church setting for biblical counseling. The Feedback Form was sent at mid-point, after session two and post, after session three from the Encourager either through text or email, whichever the Care Seeker preferred. The Intake and Encourager Feedback forms provided the data to analyze results at pre, mid and posttest on the dependent measures, personal well-being, spiritual well-being church engagement. The constructs and the instruments incorporated into the Intake and Feedback Forms, and used in the analysis, are considered next.

**Duke Health Profile**

Conceptualizing personal well-being as it relates to anxiety and depression, a common comorbid condition in those who are suffering (American Psychiatric Association, 2013; Salcedo, 2018), gives understanding that personal well-being is likely a most common condition in those who are suffering or experiencing a crisis (Kroenke, Baye, Lourents, 2019). Anxiety and depression currently provide a vast amount of empirical evidence on outcomes as a result of the various therapeutic methodologies used as an intervention in varying clinical settings. In this study, anxiety and depression are operationalized as personal well-being through a 7-question subscale of the Duke Health-Anxiety and Depression (Duke-AD) Profile.

The Duke Health Profile is a health instrument developed and validated over a 35-year period directly out of Duke University in the Department of Family Medicine and Community Health (Duke University, 2020) by Dr. George R. Parkerson. As put forth by the World Health Organization (WHO) in 2008, a person’s health was defined as well-being in the areas of physical, mental and an ability to thrive in social functioning (Parkerson, Eisenson & Campbell,
With that in mind, Dr. Parkerson (2019) and his colleagues set out to accomplish a long-term effort in measuring six health measures (physical, mental, social, general, perceived health, and self-esteem), and four dysfunctional measures (anxiety, depression, pain, and disability) as a way to measure individual health (Parkerson & Broadhead, 1990; Duke University, 2020). The scale is divided into 11 sub-scores that are tied to the six health measures and four dysfunctional measures mentioned, along with the addition of the anxiety-depression scale, also referred to as Duke-AD.

The Duke Health Profile (DHP) in its entirety, consists of 17 questions with a three-response option for questions 1-7: Yes, describes me exactly; Somewhat describes me; and No, doesn’t describe me at all, and a three-response option for questions 8-16: None, Some, and A Lot. The final question, number 17, also has a three-response option: None, 1-4 days and 5-7 days. This quantitative instrument puts to use a raw scoring method with each answer employing a two- or three-digit score based on the respondent’s answer. A raw score is the original, unaltered unit of measurement opposed to standardized or z scores where the raw score is subtracted from the population mean, then divided by the population standard deviation (Warner, 2013).

The DHP’s scoring method used a 2- and 3-digit numbers format assigned to each response. On the Intake and Feedback Forms, the responses were scored 1-3 in a Likert type scale for all answers, and then the researcher consulted the instructions the DHP scale provided. Since the original scoring from the scale were not added to the forms provided to Care Seekers, the translating process ended up being a cumbersome task and is later discussed in chapter 4 on how to better apply this instrument. Regardless, the instructions of the instrument were to take
the last digit of the initial raw score after the respondent’s answer, sum the last digit of all scores, and in the case of the Anxiety/Depression subscale, multiply the sum of scores by 7.143. For example, item #2 states, “I am not an easy person to get along with”. If the respondent answered, “Yes, describes me exactly”, a two-digit score of 12 from the DHP scale corresponds with that answer; the raw score was then recorded as 2, the last digit. Another example, the question in item #11 states, “During the past week, how much trouble have you had with hurting or aching in any part of your body?”. If the respondent answered, “Some”, a three-digit score of 101 corresponded with that answer and the raw score was recorded as 1, the last numerical value of the three-digit response. Next, the researcher was instructed to sum the last digits from the raw scores and multiply that sum by 7.143. The sum of scores provided a calculated final score for physical health, mental health, social health, general health, self-esteem, and perceived health. According to the DHP scale, a score of 100 indicated the best health status and a score of 0 indicated the worst health status. For the dysfunctional measures – anxiety, depression, pain, and disability, the reverse was true as 100 indicated the worst health status and 0 indicated the best health status.

Across three different studies that made use of the Duke Health Profile, reliability and validity showed good. The profile had a good internal reliability (Cronbach’s alpha = 0.54-0.78) and test-retest correlations were 0.30-0.78. In a more recent study for measuring population health in a Community Health Center, correlations showed better at 0.65-0.78 (Parkerson, Broadhead & Chiu-Kit, 1990; Rapin, Toussaint-Thorin, Tardieu, Darmé, Jolly & Boyer, 2013; Parkerson, et al, 2019).
Spiritual Well-Being Scale

The Spiritual Well-Being Scale (Ellison & Paloutzian, 1983) is a quantitative scale that provided a general indication of self-reported well-being (Life Advance, Inc., 2018). The scale had a total of 20 questions which consisted of two subscales that individually indicated religious well-being and existential well-being. As a whole, this scale was an instrument used to determine the health of human welfare on the spiritual dimension (1983). As early as the 1960s, subjective well-being, or quality of life, had become a way to measure overall self-reported happiness, worries and experiences of Americans (Ellison, 1983). The quality-of-life movement diverged from economic measures that were prominent in gauging the well-being of an individual, such as the acquisition of material necessities, self-fulfillment and competence, but ignored the spiritual aspect of a person. (Campbell, 1976; Ellison, 1983). A sense of well-being emerged overtime and moved into counting personal and spiritual well-being as a key factor in the overall happiness of a person who also found purpose and ultimate meaning of life (Campbell, 1976; Ellison, 1983).

Although some previous reports indicated a decline in the importance of religion in a person’s life, a recent study conducted by the Pew Research Center (2015) reported that 53% of adult Americans still considered religion as “very” important in their lives. Measuring the spiritual well-being of individuals provided a total picture of human well-being (Bufford, Paloutzian & Ellison, 1991; Ellison, 1983). In addition, measuring the spiritual well-being of those who seek help through peer-to-peer biblical soul care in the backdrop of the church, begins to lay the groundwork needed for additional scientific validity to outcomes as it relates to biblical soul care and church programs.
Using the Spiritual Well-Being Likert Scale (Ellison & Paloutzian, 1982) in this study, as it was written, provided measurement sensitivity and allowed for the possibility of more true answers since the ranking order was from negative to positive, or low to high (Hartley, 2013; Warner, 2013). The Spiritual Well-Being Scale (Ellison & Paloutzian, 1982) made use of a six-point Likert scale that ranged from (1) Strongly Disagree to (6) Strongly Agree. However, responses from the Spiritual Well-Being Scale (SWBS) on the Intake Form (pretest) and Feedback Form (mid and posttest) were inadvertently listed and scored as follows: (1) Agree, (2) Moderately Agree, (3) Strongly Agree, (4) Disagree, (5) Moderately Disagree, and (6) Strongly Disagree. Scoring range on the original instrument was 20-120 points, 20 being the lowest possible score for a Care Seeker to self-report if all questions were answered with (1) Strongly Disagree, and 120 being the highest possible score if all questions were answered with (6) Strongly Agree. Further instruction on the scale was provided for the user to reverse score for negatively worded items, noting that items were scored from 1 to 6, with a higher number representing more well-being. Odd-numbered items assessed religious well-being and even numbered items assessed existential well-being. Coefficient alphas are (.89) and test-retests are .93, showing there is sufficiently high internal consistency and reliability (Ellison, 2006). Permission was required for use of this scale and was obtained from Life Advance, Inc. via email from Dr. Raymond F. Paloutzian on June 20, 2017 (Appendix C).

**Church Engagement**

Church engagement, specifically in the areas of serving in the church, joining a small group, or going on a mission trip, was developed as a pilot measured construct in this study to determine if a Care Seeker would become, remain involved or increase involvement in church community as a result of the Encourager Program. Many studies and article reviews showed a
consistency in findings where religious involvement or church attendance correlated to better health outcomes (Mueller, Plevak, & Rummans, 2001; Koenig, 2012; Peteet & Balboni, 2017; VanderWeele, 2017). However, there was little to no discussion in research surrounding whether or not the opposite impact holds true. This research adds to the foundation being laid for future researchers, who desire to discover whether or not a pure, peer-to-peer peer biblical soul care program offered in a church environment, could make a statistically significant difference in church engagement. Great precaution on conclusions were taken, noting more studies will be needed to substantiate any evidence on whether or not there would be any statistically significant difference. To begin positioning this important foundational work, two church engagement questions were included in the Intake and Feedback Forms that asked: (Q1) “How long have you attended Hope Church?” and, (Q2) “If you are attending, or are a member of Hope Church, are you involved in any of the following?” Responses were set up to provide a nominal level of measurement and were as follows: (Q1) 1 = I do not attend Hope Church, 2 = Less than 2 years, 3 = 2-5 years, 4 = 6-9 years and 5 = 10+ years. Responses for the second question (Q2) were also nominal and scored 1-6 respectively as follows: 1 = Volunteer (i.e., Greeter, Next Steps, Usher, Children’s Ministry, Choir, other), 2 = Small Group, 3 = I have been on a mission trip, 4 = I would like more information about going on a mission trip, 5 = I would like more information on connecting in one or more of the above, and 6 = None of the above.

During data collection, it was noted that church engagement responses did not provide quantitative data but rather, produced frequencies. A quick determination was made by the researcher to continue in the analysis with the information provided and report as such. Although there was evidence of the possibility that when a respondent’s score changed, for example from (6) None of the above at pretest, to (2) Small Group at mid or posttest, the change could
potentially have indicated that the Encourager Program made a difference in church engagement. The original intent was to determine whether or not peer-to-peer biblical soul care would help a Care Seeker become involved, maintain or increase church engagement however, due to the construction of the questions and the responses available to choose from, there was not sufficient quantitative measures for the statistical analysis decided upon at the start of the study. In light of the inept data, the researcher determined it appropriate to use the frequencies for church engagement and continue on with the one-way repeated measures ANOVA for personal well-being and spiritual well-being independently.

The two church engagement questions mentioned above, along with the personal well-being subscale in the Duke Health Profile (Parkerson, et al, 1990), and the Spiritual Well-Being Scale (Ellison & Paloutzian, 1982) were incorporated into the Intake Form (pretest; Appendix D) and the Feedback Form (mid and posttest; Appendix E) developed by the Director of the LIFE Center. The numerical values assigned to the 7-point subscale in the Duke Health Profile (Parkerson, et al, 1990), the 20-point Spiritual Well-Being Scale (Ellison & Paloutzian, 1982) provided quantitative results, and the church engagement questions provided frequencies. The structure and content of the Intake and Feedback forms are described next.

The Intake and Feedback Forms

Intake Form. The Intake form was completed as a request for care (pretest) by the Care Seeker and consisted of the Care Seeker’s contact information, basic demographics, the Duke Health Profile – Anxiety and Depression subscale (Parkerson, et al, 1990) to measure personal well-being, the Spiritual Well-Being Scale (Ellison & Paloutzian, 1982) to measure spiritual well-being, and the two church engagement questions. Additionally, the Care Seeker was asked how he or she heard about the LIFE Center, to briefly describe the situation they were seeking
counsel for, whether or not their situation was discussed with anyone else, and the ability to rate the severity of the situation on a scale of 1-10 (1 meaning non-crisis, 10 meaning crisis). The Care Seeker was instructed to contact 9-1-1 if they considered their situation an emergency. The Intake form concluded with the Care Seekers’ electronic initials acknowledging that Encouragers in the LIFE Center were not licensed or clinical professionals but were trained peers offering encouragement and biblical soul care and counsel.

**Feedback Form.** At the end of session two and three, the Encourager sent the Care Seeker a link to the Feedback form (Appendix E), a Wufoo form created on the Survey Monkey web-based platform, via email or text, whichever the Care Seeker preferred. The Feedback form was initially developed by the Director of the LIFE Center as a way to provide feedback and training to the Encourager as they cared for those who contacted the LIFE Center. For purposes of this study, the Feedback form was used to collect mid and posttest outcomes of the dependent variables and included basic contact and demographic information, the same Duke Health Profile – Anxiety and Depression Scale (Parkerson, et al, 1990), Spiritual Well-Being Scale (Ellison & Paloutzian, 1982) and the two church engagement questions provided in the Intake Form. This allowed for analysis between the means of three levels of a within-subjects factor, pre, mid and posttest.

Additionally, in the Feedback form, Care Seekers were asked to rate how pleased they were with how long it took for the first contact from the LIFE Center, and how pleased they were with how long it took an Encourager to make first contact to schedule the first session. The response was scored as 1 being extremely dissatisfied to 10, being extremely satisfied. This information was not used in this study, but rather was a measure to help Encouragers improve in
response time and assist in growth discussions and training between the Director and the Encouragers.

**Procedures**

This section lists the steps taken to conduct this study. First, the process taken to secure approval from the International Review Board (IRB) as well as the reason for a modified submission are listed. Second, the methodology used to obtain the convenience sample and how data points were collected during intake are discussed. Third, how an Encourager and Care Seeker were connected to implement the Encourager Program are detailed. Fourth, details on how the Encouragers were trained are discussed. Fifth, administration of the procedures was considered. Sixth, details on how data was gathered are provided, followed by the procedures implemented for recording the data collected.

**International Review Board (IRB) Approval**

The student presented and passed her proposal defense on November 8, 2019. Next, she submitted her application to IRB on March 20, 2020 and on April 2, 2020, IRB approved an initial proposal for this study with a power analysis that revealed a need for a sample size of $N = 56$ to produce a .50 effect size, a confidence interval of .95, and $p = .05$ (Faul, Erdfelder, Buchner, & Lang, 2009). However, just prior to receiving approval from IRB to begin data collection, Coronavirus (COVID-19), a virus that reportedly originated in the city of Wuhan, China in December 2019, quickly expanded into a global pandemic with the first case reported in the United States on January 21, 2020. Rather quickly, governments around the world issued stay at home orders except for essential workers, as early as February 2020 (Salari, Hosseinian-Far, Jalali, Vaisi-Raygani, Rasoulpoor, Mohammidi, Rasoulpoor, & Khaledi-Paveh, 2020; World Health Organization, 2020; Moreland, Herlihy, Tynan, Sunshine, McCord, Hilton, Poovey,
Werner, Jones, Fulmer, Gundlapalli, Strosnider, Potvien, García, Honeycutt, & Baldwin, 2020). An in-depth discussion follows due to its significant impact on the smaller sample size for this study.

Following the first reported case of COVID-19 in the United States by the Center for Disease Control (Moreland, et. al., 2020; American Journal of Managed Care, 2020), California became the first state in America to issue a statewide stay-at-home order on March 19, 2020. The closure in California swiftly led to the closure of 41 other states, including the state of Nevada (AJMC, 2020; Moreland, et. al., 2020). On March 20, 2020, weeks before IRB’s initial approval of this study, the Governor of Nevada issued a Declaration of Emergency Directive 003, ordering the closure of all non-essential businesses and restricting activities in essential businesses as a way to mitigate the spread of COVID-19 (Nevada Governor, 2020). At the time, churches were not considered essential and Hope Church, along with the LIFE Center ministry, closed and transitioned all church staff and volunteers to work remotely from home. Shortly thereafter, Encouragers who served in the LIFE Center began offering peer-to-peer biblical soul care to those who contacted the LIFE Center for care via Zoom, a secure web-based video conferencing platform. In light of the transition home and moving on to Zoom’s platform, the researcher recognized that a modified application needed to be resubmitted to IRB to acknowledge the transition from the original method of administering the Encourager Program in person, to providing the program over Zoom. The modification was submitted on April 9, 2020 and IRB provided final approval to implement the use of Zoom and begin data collection on April 10, 2020.

As a result of the closure of the state of Nevada, specifically in the city of Las Vegas, the intake process for participants came to a complete halt for at least the first three months after the
stay-at-home order was issued. On average, prior to the pandemic, 25-30 individuals contacted the LIFE Center to meet with an Encourager. When stay-at-home orders were issued, a sharp decrease from 25-30 to zero individuals contacted the LIFE Center for help. Later, when the Governor allowed some businesses and other entities to open with conditions, a steady, but slight incline of participants resumed but remained low, 3-5 participants per week, compared to intake prior to COVID-19. It was determined by faculty and the researcher to not wait until the N of 56 participants was reached but to continue on with analysis on the smaller sample size obtained of N = 5 participants. In doing so, the researcher would clearly state the implications, limitations and recommendations discussed further in chapter 5. The next section explains the methodology and data collection process for the smaller sample size (N = 5).

**Procedure for Sample and Data Collection**

Care Seekers were made aware of the LIFE Center when they attended Hope Church, were referred by a friend, through social media or a search engine on the Website. Care Seekers contacted the LIFE Center for biblical soul care via email, phone call or the LIFE Center’s webpage and completed the ‘Contact Me’ form found either on the website, or in a link sent via email. When a Care Seeker initiated contact with the LIFE Center and asked for counseling, an email was sent from either the Administrative Assistant or the Director. The email sent welcomed the Care Seeker, explained the services offered through the LIFE Center, and invited him or her to set up a Biblicare© account via a link provided in the welcome email.

When the Care Seeker clicked on the link, it would direct the Care Seeker to Biblicare©, a secure web-based platform created specifically for biblical counseling intake conducted in the context of churches. Once the Care Seeker was in Biblicare©, the opportunity to create a secure account was presented and from there the Care Seeker accessed and completed the Intake form.
When the Intake form was completed, the Care Seeker was guided to click the ‘Request Care’ button and the Administrative assistant and Director were notified via email that a new case had been created. When a staff member received the email notification that a new case had been created, a connection between the Encourager and Care Seeker was made within the Biblicare© database.

Next, when the administrative assistant or Director received notification that a new case was added in Biblicare©, she assigned the Care Seeker’s account to an Encourager. The Encourager was notified via email that they had been assigned a new case, which is a new Care Seeker. Encouragers were taught during training to make contact within 24-hours of being notified via email. At the point of contact, the first appointment was scheduled for session 1, followed by scheduling session 2 at the end of the first session, then scheduling session 3 at the end of session 2 when all sessions were completed. As stated earlier, the protocol was to connect male Care Seekers with male Encouragers and female Care Seekers with female Encouragers. Those who administered the Encourager Program were provided training before engaging Care Seekers. As stated previously, the training was delivered through the LIFE Center in a 5-week training module referred to as Foundations Training (Appendix A).

**Foundations Training for Encouragers**

Encouragers who provided the intervention in this study, were previously trained and had been active volunteers in the LIFE Center anywhere from 1-4 years. As previously stated, Foundations Training (Appendix A) was a 5-week training that consisted of three weeks of training directly on the Encourager Program through a video-based curriculum created by Seacoast Church (2018), followed by a two-week overview of Dr. Larry Crabb’s (2005) work, *Connecting*. The original intent of the full module established by the Director five years prior
before this study began, was to provide specific training on how to be an Encourager, as well as a foundational understanding of the “how” and “why” behind the manner in which peer-to-peer biblical soul care was administered in a church setting. Since the church is considered a front-line resource as mentioned in chapter 1, this provided an opportunity for the Encourager Program to be understood as more of a way to triage a situation and make the appropriate connection for those who are hurting. Undergirding the method of the type of biblical soul care provided in this peer-to-peer setting, was the notion that as Encouragers, the goal was not to “fix” or provide “treatment” to the problem a Care Seeker presents with but rather, a call to come alongside a Care Seeker to hear their story, speak God’s truth into the situation as applicable, and together determine what the next best step could be for the Care Seeker. These three steps provided the approach used to administer the Encourager Program and were discussed earlier in this chapter.

As a result of this study, additional training was provided to the Encouragers on how to proceed with obtaining consent and the additional submission of the Feedback form at midtest, after session two. Prior to this study, when the Care Seeker completed the Intake form and was connected with an Encourager of the same gender, the Care Seeker received the Feedback form once at the end of the third session when three sessions were completed. In an effort to gain more data, as well as being aware that all Care Seekers did not complete all three sessions, additional training was provided from the researcher to give instruction on how to ask for consent to use responses in this study and, ask for an additional Feedback form to be completed after session two (mid measure), along with the final one after session three (post measure). Doing so allowed for the pre, mid and posttest measures and provided support for the use of the one-way repeated measures ANOVA. The process on how collection occurred is further detailed next.
Keeping in mind the stay-at-home orders issued due to the pandemic, a Zoom call was scheduled with the Director to instruct the Encouragers on how to implement the additional steps needed specifically for the duration of this study that began in May 2020. The researcher asked and was given approval from IRB to have the Encourager ask for consent at the end of session one. Asking for consent at the end of the first session, rather than before session one, was an honest effort to remove any potential concern that the Care Seeker would not receive care if consent was declined, and to build a strong therapeutic alliance. The administering of the intervention is described in greater detail in the next section.

**Procedures for Administering the Encourager Program**

The Encourager program consists of three sessions – Session 1 “Story”, Session 2 “Truth”, and Session 3 “Next Steps”. The program was administered, ideally, over a three-week period in one-hour sessions with a trained peer, known as an Encourager. Encouragers were volunteers and some of them worked full-time outside of their volunteer service in the LIFE Center. They managed their own schedules and when unavailable, were empowered to ask to be passed up until the next time through the list of Encouragers. As described earlier in this chapter, the goal was for the Encourager and Care Seeker to meet for three sessions in an eight-week period however, $N$ of 3 participants completed three sessions, and $N$ of 2 participants completed two sessions in this study as shown in Figure 1.
Due to Care Seekers not completing all three sessions, for purposes of this study, it was considered that a Care Seeker completed the Encourager program in a minimum of three weeks or a maximum of eight weeks. In the event a Care Seeker and Encourager did not meet for all three sessions, personal well-being and spiritual well-being were measured following session two as a midpoint measure, provided the Care Seeker attended at least two sessions.

At the end of the first session, the Encourager was trained to invite the Care Seeker to participate in this study and explain that no identifying information would be included. The step to ask for consent after the first session, was intentional and approved by IRB. Asking for consent at the end of session one allowed for an Encourager to build a relational alliance with the Care Seeker and, avoid any adverse feeling the Care Seeker could potentially develop that he might not receive care if consent was not provided. If the Care Seeker declined participation, the Encourager continued with scheduling the next session. If the Care Seeker agreed, the
Encourager further explained that he would receive an email with the consent form and letter of intent. Consent was provided to use gender, age range and responses in the study with no other identifying information. The Care Seeker was encouraged to read both documents and if agreed, was asked to reply to the email with their electronic signature and date. That email was forwarded to the Director and electronically filed on the researcher’s secure laptop. A second session was scheduled and at the end of that session, the Encourager emailed or text a link for the Feedback Form (midtest) to the Care Seeker, and again after the third session. Since the researcher was not present in the sessions to ensure directions were provided appropriately, it is difficult to claim fidelity. Including questions on the Feedback form to clarify if instructions were given appropriately is a recommendation that will be discussed further in chapter 5.

**Procedures for Gathering Data**

Data was collected for each Care Seeker from the instruments and forms previously mentioned and incorporated into the Intake and Feedback forms (Appendix D & E). As noted, the three self-reporting instruments used for this study were the Duke Health Profile – Anxiety and Depression Scale (Parkerson, Broadhead & Tse, 1990) to measure personal well-being (pwb), Spiritual Well-Being Scale (Ellison & Paloutzian, 1982) to measure spiritual well-being (swb), and the two-church engagement (ce) questions developed by the Director. Each question on the DHP-AD and SWB scales gave quantitative measures and provided the ordinal data needed for the statistical analysis to test the hypotheses. Church engagement provided frequencies to observe.

The questions on the Intake and Feedback forms to test, pwb, swb and ce were the same at pre, mid and posttest and provided the data used in the analysis for this study. First, when the Intake form (pretest) was received, the Director removed all identifying information and replaced
the name of the Care Seeker with an identifying code number, i.e., 01, 02, etc. The code number and the associated data were used in analysis: age, gender and the responses from the instruments that provided pwb, swb and ce data scores. Pretest data was entered into a spreadsheet in Microsoft Excel® on the researcher’s secure laptop, prior to it being entered into SPSS 27 where data analysis was conducted. Next, if the Care Seeker completed session two (midtest), the Feedback form was returned directly to the Director via email, and the same process of replacing identifying information with an identifier code and entering midtest data scores into Microsoft Excel® were completed. Finally, the same steps completed after session two for midtest data scores, were repeated after session three for posttest scores. The data for this research was obtained from the steps taken as explained and provided the outcomes presented in chapter 4.

Next, is an illustration of the variables, pwb, swb and ce, and how they were recorded for analysis.

**Procedures for Recording Data Collected**

The Intake and Feedback Forms provided dependent variable outcomes for personal well-being (pwb), spiritual well-being (swb), and church engagement (ce). These constructs were measured by 3 within-subjects’ factors, pre, mid and posttest. To prepare for entry into SPSS 27, the variables used in this study were given variable abbreviations. The pretest variable abbreviations for personal well-being were pwb_pre, spiritual well-being was swb_pre, and church engagement was ce_pre. Midtest variables were entered as pwb_mid, swb_mid and ce_mid. Finally, posttest variables were assigned as pwb_post, swb_post, and ce_post. Scores were first entered into a Microsoft Excel® spreadsheet as described earlier, then transferred into SPSS using the variable abbreviations listed above.
Once data was entered into Microsoft Excel®, a simple preliminary data screening was conducted on the five participants to detect for entry errors, missing values, and/or extreme outliers (Warren, 2013). Then, data was transposed from the spreadsheet and manually entered into SPSS 27. To set up the SPSS data sheet, a new file was opened, and under variable view, the researcher entered two demographics labels on the y-axis, Age and Gender. Entered next were the dependent variables and the three levels they were measured at. Since one line represented a Care Seeker, the dependent variables being measured were entered straight across the y-axis. Since church engagement outcomes became descriptive in nature, results for each question were entered as follows: ce_preQ1, ce_midQ1, ce_postQ1, ce_preQ2, ce_midQ2, ce_postQ2. Scores used for personal well-being and spiritual well-being were the sum of the mean difference and were entered as follows: pwb_pre, pwb_mid, pwb_post, and swb_pre, swb_mid and swb_post. Once was entered into SPSS, the researcher clicked on data view and proceeded to transfer data scores from Microsoft Excel® to SPSS. All data was saved on the researcher’s secure laptop. Once data was recorded, a one-way repeated measures ANOVA was run to determine outcomes.

**Data Analysis**

As noted, this quasi-experimental design study was crafted to observe the effect of the Encourager Program on personal well-being, spiritual well-being, and church engagement through a one-way repeated measures ANOVA run in SPSS 27. As specified, the rationale for using this particular analysis was due not only to having a small sample size, but also because the same participants were measured at three different levels on the same dependent variable (Warner, 2013; Laerd Statistics, 2021). Power analysis provided an initial target of \( N = 56 \) participants however, due to the pandemic, sample size was smaller and data analysis was conducted for \( N = 5 \) participants. Once the decision to proceed with a smaller sample size was
determined appropriate by the researcher and faculty, data screening procedures and analysis commenced.

A one-way repeated measures Analysis of Variance (ANOVA) was run to determine if there was a statistically significant difference between the three levels of a within-subjects factor (Figure 2) (Warner, 2013; Laerd Statistics, 2021). All three levels were included in data entry provided the Care Seeker completed the third session. If the Care Seeker did not complete the third session but completed the first and second sessions, at the end of an eight-week period the researcher analyzed data from the same output given from the one-way repeated measures ANOVA analysis. Rather than apply imputation of missing data for $N$ of 2 participants who did not complete the final session, the researcher excluded the system missing values concluding that the process of imputation (Warner, 2013) would be futile and make little difference in final analysis. Variances were analyzed between pre and midtest for all Care Seekers to detect if there was a statistically significant difference in personal well-being, spiritual well-being, and church engagement after two (pre and mid) and three sessions (pre, mid and post). The outcomes from the data analysis provided tested the hypotheses mentioned next for this study.
Figure 2

One-Way Repeated Measures ANOVA

Hypotheses

The first hypothesis tested as it relates to personal well-being predicted that when a Care Seeker received peer-to-peer biblical soul care through the Encourager Program, personal well-being would increase after midtest when compared to pretest and increase again at posttest when compared to pretest. Toward spiritual well-being, the researcher predicted that spiritual well-being at mid-test would increase, and at posttest would increase when compared to pretest scores. The last two hypotheses predicted toward church engagement that the Care Seeker would remain involved, become involved, or increase involvement in church as a result of the Encourager Program at midtest when compared to pretest results and at posttest when compared to pretest results. To test the above hypotheses, a one-way repeated measures ANOVA was conducted for data analysis.
Concise Rationale and Assumptions

The overarching theory in this study was that peer-to-peer biblical soul care offered in the context of a church could make a statistically significantly difference. This study set out to determine if the dependent variables, personal well-being (pwb), spiritual well-being (swb) and church engagement (ce) were impacted after two or three sessions in the Encourager Program. The one-way repeated measures ANOVA was appropriate for the analysis in this research because it helped effectively determine if there were any statistically significant differences between the means of two or more levels of within-subject factors and calculate the $F$ ratio used to assess statistical significance, or $p < .05$.

The first two assumptions for the ANOVA analysis related to the design of this study were met since there was at least one independent variable, the Encourager Program, and three dependent variables, personal well-being, spiritual well-being and church engagement. The assumptions remaining for ANOVA reflect the nature of the data, i.e., having no significant outliers, having an approximately normally distributed dependent variable, showing variances of the differences between the within-subjects factor as equal, as well as the requirement for the distribution of the differences between two related groups to be symmetrical (Laerd Statistics, accessed 2019) and are discussed in chapter 4.

Summary

In conclusion, the quasi-experimental design of this study attempted to bring about much-needed empirical evidence as it related to quantifying peer-to-peer biblical soul care in the scientific community. However, due to the global pandemic that occurred, this study instead potentially accomplished clarity on a solid methodology for the continuation of further research from the lessons learned and the results that were obtained from the minimal sample size. The
expectation that the Encourager Program, administered by trained volunteers, would indeed have an impact on the personal well-being, spiritual well-being, and church engagement of those who sought care through the church, while not proven in this study, possibly disclosed a valid need to pursue further research on more church programs. A pursuit could reveal the church as more than a front-line resource, but theoretically as a scientifically validated front-line resource. It was critical to interpret the findings in the next chapter with great caution due to the limitations mentioned earlier of a quasi-experimental design, as well as the fact that sample size was small as a result of the global pandemic. Participants in this study then are not completely culturally and demographically reflective of the population at Hope Church or in the city of Las Vegas.

Finally, this study tested the alternate hypothesis, not directly the null hypothesis, or an inferential statistical test comparing the two. The alternate hypotheses were tested which indirectly inferred the researcher could reject the null hypothesis. However, statistical power was not present, and regardless of the extreme reduction of participants, results from statistical analysis were provided below on a smaller convenience sample size ($N = 5$). Since statistical power has a direct link to sample size (Warner, 2013; Morgan, 2017), the ability to detect a small to moderate effect size dissolves, but greatly increases the detection of a large effect size (Warner, 2013; Morgan, 2017). This research now serves as more of a pilot study for future researchers, offering the advantage of observing the type of results which may not have been as prevalent had there been a more robust sample size as it pertains to a large-scale study. The possibility that a difference between groups could be found when in fact one does not exist was high, thus committing a Type I error (Warren, 2013). As well, it was also highly possible to discover a difference and not be able to identify it, thus committing a Type II error (2013). In this study in particular, in spite of its limitations, it was initially hypothesized that outcome variables
would show a statistically significant difference when an unidentifiable difference actually existed, rejecting the null hypothesis, and avoiding a Type II error.
CHAPTER FOUR: FINDINGS

Overview

The overall objective for this body of research was to determine if the independent variable, the Encourager Program, created any statistically significant difference in three dependent variables, personal well-being, spiritual well-being and church engagement at three levels – pre, mid and posttest. This chapter starts with descriptive statistics, the data merely as it is, with no inferences toward a larger population. The data highlights the demographics and the dependent variable, frequencies for church engagement followed by results of each hypothesis. A total of six hypotheses were discussed at length in chapters 1 and 3, this chapter includes a discussion of the results. Finally, this chapter ends with a conclusive summary of what has been discussed.

Descriptive Statistics

Descriptive statistics reveal overall results for age, gender, and specifically for the dependent variable, church engagement. Characteristics reveal that all participants were female \((N = 5)\), and an inclusion of 4 variable age ranges are shown in Table 1. As it relates to sessions attended, previously noted in chapter 3 of the potential all Care Seekers would not attend all 3 sessions, \(N\) of 3 attended three sessions and \(N\) of 2 attended the first two sessions, providing complete results for \(N = 5\) for pre and midtest, and complete results for \(N = 3\) for pre, mid and posttest outcomes as shown in Table 2.

Demographics of Convenience Sample

**Age.** The age ranges for the 5 participants in this study were 34-41yrs \((N = 2)\), 50-57yrs \((N = 1)\), and 65+yrs \((N = 2)\) shown in Table 1.
**Gender.** The total sample size of \( N = 5 \) for this study consisted of 5 female and 0 male participants also shown in Table 1.

Table 1

**Demographics of Participants**

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>( N )</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Range 34-41yrs</td>
<td>2</td>
<td>40.0</td>
</tr>
<tr>
<td>50-57yrs</td>
<td>1</td>
<td>20.0</td>
</tr>
<tr>
<td>58-64yrs</td>
<td>1</td>
<td>20.0</td>
</tr>
<tr>
<td>65+yrs</td>
<td>1</td>
<td>20.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5</td>
<td>100.00</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
<td>100.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5</td>
<td>100.00</td>
</tr>
</tbody>
</table>

**Church Engagement**

Church engagement was tabulated as frequencies provided in Table 2. Although \( N = 2 \) participants did not attend session 3, effects at pretest and midtest showed \( N = 3 \) respondents attended Hope Church for less than 2 years, \( N = 1 \) attended between 2-5 years and \( N = 1 \) attended between 6-9 years. At posttest there were only \( N = 3 \) Care Seekers who participated, and frequencies adjusted to \( N = 1 \) attended Hope less than 2 years, \( N = 1 \) attended between 2-5 years, \( N = 1 \) attended between 6-9 years, and as stated, \( N = 2 \) did not attend session three. In a similar way, when it came to the ceQ2 at pretest, \( N = 2 \) respondents indicated they were volunteering, \( N = 1 \) noted involvement in small group, and \( N = 2 \) stated they would like more information on connecting in one or more of the above options. At midtest, frequencies showed that \( N = 2 \) were volunteering, involvement in small group increased to \( N = 2 \) and a response indicating a want for more information on the above decreased to \( N = 1 \). Additionally, a response from \( N = 1 \) was
missing from ceQ2. Since there is no way to convincingly show that to be true, no conclusions were made at this time. Implications of this outcome are elaborated on in the results section.

Table 2

*Church Engagement Pre, Mid and Posttest (ce_pre, ce_mid, ce_post)*

<table>
<thead>
<tr>
<th>Factor</th>
<th>Response</th>
<th>N</th>
<th>Ce_pre</th>
<th>N</th>
<th>Ce_mid</th>
<th>N</th>
<th>Ce_post</th>
</tr>
</thead>
<tbody>
<tr>
<td>ce Q1</td>
<td>(1) I do not attend Hope</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2) Less than 2 years</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(3) 2-5 years</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(4) 6-9 years</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(5) 10+ years</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Missing</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>5</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ce Q2</td>
<td>(1) Volunteer (i.e., Greeter, Next Steps, Usher, Children’s Ministry, Choir, other)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2) Small Group</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(3) I have been on a mission trip</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(4) I would like more information about going on a mission trip</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(5) I would like more information on connecting in one or more of the above</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(6) None of the above</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Missing</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>5</td>
<td>5</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Personal and Spiritual Well-Being**

Descriptive statistics for personal well-being (pwb) and spiritual well-being (swb) illustrate Mean (M), standard deviation (SD) and the number of participants measured at all three time points. Table 3 shows pwb_pre with N = 3, M = 35.715; SD = 7.143; pwb_mid, N = 3, M = 40.477, SD = 8.248; and pwb_post, N = 3, M = 40.477, and SD = 10.911. Table 4 shows spiritual well-being as swb_pre, N = 3, M = 49.333, SD = 8.326; swb_mid, N = 3, M = 49.000, SD = 7.549; and swb_post, N = 3, M = 48.333, SD = 7.505.
Table 3

Descriptive Statistics for Personal Well-Being

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>pwb_pre</td>
<td>35.7150</td>
<td>7.14300</td>
<td>3</td>
</tr>
<tr>
<td>pwb_mid</td>
<td>40.4770</td>
<td>8.24803</td>
<td>3</td>
</tr>
<tr>
<td>pwb_post</td>
<td>40.4770</td>
<td>10.91111</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 4

Descriptive Statistics for Spiritual Well-Being

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>swb_pre</td>
<td>49.3333</td>
<td>8.32666</td>
<td>3</td>
</tr>
<tr>
<td>swb_mid</td>
<td>49.0000</td>
<td>7.54983</td>
<td>3</td>
</tr>
<tr>
<td>swb_post</td>
<td>48.3333</td>
<td>7.50555</td>
<td>3</td>
</tr>
</tbody>
</table>

Results

This section provides results from assumptions that were tested and reported any violations as a result of the small sample size. Then, a discussion on results is reported from analysis using the one-way repeated measures ANOVA run on personal well-being (pwb) and spiritual well-being (swb). Next, the alternate and null hypotheses were tested, and outcomes were reported. Finally, an overall observation and summation of the analysis on the variables tested were made in context of the literature, other studies and theories in the conclusion. It is incumbent on the researcher to acknowledge that the low sample size obtained in this study would ordinarily impede a researcher from analyzing statistics due to the lack of power needed \((d = .50, CI = .95, and p = .05)\), as obtained by power analysis acknowledged in chapter three (Faul, Erdfelder, Buchner, & Lang, 2009). The lack of power analysis would normally result in the need for continued data collection however, to demonstrate competency in conducting a research study and comprehension of analysis, the following is presented.
Assumptions

Keeping in mind the lack of statistical power for this study, assumptions need to be addressed prior to reporting results since three of them reflect the nature of the data and could not be discussed until after data collection. There are a total of five assumptions required to be met for the one-way repeated measures ANOVA. The first two assumptions have to do with study design and were met for this study. The first assumption needed to have at least one independent variable measured at the continuous level, the Encourager Program met this assumption. The second assumption stated the need to assure there was at least one within-subjects factor that consisted of three or more categorical levels (Laerd Statistics, 2020). The three dependent variables, personal well-being (pwb), spiritual well-being (swb) and church engagement (ce), measured at pre, mid and posttest met the second assumption.

The other three assumptions were directly related to the data. The third assumption stated there should be evidence of no significant outliers. Prior to running data analysis, all data points were kept from the small sample size (N=5), and after using the Explore option in SPSS 27, boxplots showed no outliers, extreme or otherwise. The fourth assumption noted that dependent variables should be approximately normally distributed for each level of the within-subjects factor. Assumption of normality is needed to show statistical significance in a one-way repeated measures ANOVA (Laerd Statistics, 2020). Since the ANOVA that was run in this study is considered a robust analysis to violations of normality, it is proper to only require approximate normality in the data (Laerd Statistics, 2020). Tests of normality were reviewed and since a small sample size is observed, a casual observation of the Shapiro-Wilk test showed the following results (as shown in Table 5): a total of 6 levels are displayed, 3 levels representing personal well-being (pwb_pre, pwb_mid, pwb_post), and 3 levels representing spiritual well-being
(swb_pre, swb_mid and swb_post). Out of the 6 time points, or levels, 3 are normally distributed meaning the assumption of normality is met \((p > .05)\) as it relates to pwb_pre, pwb_post and swb_mid; and 3 levels are not normally distributed, meaning the assumption of normality is violated \((p < .05)\) as it relates to pwb_mid, swb_pre and swb_post (Table 5). In light of the differences in violation of normality being met in 3 levels and violated in 3 levels, as well as the one-way repeated measures ANOVA being fairly robust to deviations from normality (Laerd Statistics, 2020), pwb and swb were both normally and not normally distributed as assessed by Shapiro-Wilk’s test (Laerd Statistics, 2020). The researcher has selected to carry on regardless using the one-way repeated measures ANOVA analysis to test the hypotheses for pwb and swb.

Table 5

<table>
<thead>
<tr>
<th>Statistic</th>
<th>df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>pwb_pre</td>
<td>1.000</td>
<td>3</td>
</tr>
<tr>
<td>pwb_mid</td>
<td>.750</td>
<td>3</td>
</tr>
<tr>
<td>pwb_post</td>
<td>.964</td>
<td>3</td>
</tr>
<tr>
<td>swb_pre</td>
<td>.923</td>
<td>3</td>
</tr>
<tr>
<td>swb_mid</td>
<td>.987</td>
<td>3</td>
</tr>
<tr>
<td>swb_post</td>
<td>.750</td>
<td>3</td>
</tr>
</tbody>
</table>

The fifth assumption for this analysis is related to sphericity, a condition where the variances of sphericity in the differences between all combinations of related levels are assumed to be equal (Warner, 2013; Laerd Statistics, 2020). To determine whether or not sphericity was met, Mauchly’s Test of Sphericity was run on pwb and swb and revealed that pwb met the assumption of sphericity \((p = .60)\), with an approximate Chi-Square of 1.02 and \(df = 2 (X^2(2) = 1.02, p = .60)\) as shown in Table 4 (Laerd Statistics, 2020). Alternatively, Mauchly’s test of sphericity showed swb violated the assumption of sphericity \((p = .047)\), with an approximate Chi-Square value of 6.11 and \(df = 2 (X^2(2) = 6.11, p = .047)\) as shown in Table 6. To be sure, the
one-way repeated measures ANOVA is reportedly biased and can easily return statistically significant outcomes (Laerd Statistics, 2020). In a larger sample size, the researcher predicted there would be statistical significance ($p < .05$), violating assumption of sphericity in both pwb and swb, which would position the researcher to reject the null hypotheses tested for both dependent variables. As well, since swb violated the assumption of sphericity, meaning the one-way repeated measures is biased, a correction could be made to correct for bias by adjusting the $df$ (Laerd Statistics, 2021). In the case of swb, Greenhouse-Geisser and Huynh-Feldt were casually observed to show that swb met the assumption of sphericity, an estimate of epsilon of a .50 ($p = .50$) significant statistical value in both Greenhouse and Huynh, also shown in Tables 6 and 7, just as pwb had.

Table 6

Mauchly’s Test of Sphericity$^a$

<table>
<thead>
<tr>
<th>Within Subjects Effect</th>
<th>Mauchly’s W</th>
<th>Approx. Chi-Square</th>
<th>df</th>
<th>Sig.</th>
<th>Greenhouse-Geisser</th>
<th>Epsilon$^b$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>.360</td>
<td>1.022</td>
<td>2</td>
<td>.600</td>
<td>.610</td>
<td>1.000</td>
</tr>
</tbody>
</table>

$^a$Design: Intercept
Within Subjects Design: Time

$^b$May be used to adjust the degrees of freedom for the averaged tests of significance. Corrected tests are displayed in the Tests of Within-Subjects Effects table.
Table 7

Mauchly’s Test of Sphericity^a

<table>
<thead>
<tr>
<th>Within Subjects Effect</th>
<th>Mauchly’s W</th>
<th>Approx. Chi-Square</th>
<th>df</th>
<th>Sig.</th>
<th>Epsilon^b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>.002</td>
<td>6.11</td>
<td>2</td>
<td>.047</td>
<td>.501</td>
</tr>
</tbody>
</table>

^aDesign: Intercept
Within Subjects Design: Time

^bMay be used to adjust the degrees of freedom for the averaged tests of significance. Corrected tests are displayed in the Tests of Within-Subjects Effects table.

One-Way Repeated Measures ANOVA Results on Personal and Spiritual Well-Being

When it came to examining outcomes in a one-way repeated measures ANOVA, since the assumption of sphericity was violated as reported in Mauchly’s test, results for pwb and swb were interpreted through Greenhouse-Geisser in the Tests of Within-Subjects Effects (Tables 8 and 9) and pwb was not statistically significant (p = .33) at the different time points overtime during the intervention, $F(1.220, 2.439) = 1.60, p > .05$. As well, swb also was not statistically significant (p = .82) at the different time points overtime during the intervention, $F(1.001, 2.002) = 1.60, p = .82$ as shown in Tables 6 and 7.

Table 8

Tests of Within-Subjects Effects

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>time</td>
<td>Greenhouse-Geisser</td>
<td>45.353</td>
<td>1.220</td>
<td>37.190</td>
<td>1.600</td>
<td>.328</td>
</tr>
<tr>
<td>Error(time)</td>
<td>Greenhouse-Geisser</td>
<td>56.692</td>
<td>2.439</td>
<td>23.244</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 9

Tests of Within-Subjects Effects

Measure: swb

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>time Greenhouse-Geisser</td>
<td>1.556</td>
<td>1.001</td>
<td>1.554</td>
<td>.073</td>
<td>.821</td>
<td>.035</td>
</tr>
<tr>
<td>Error(time) Sphericity Assumed</td>
<td>42.444</td>
<td>2.002</td>
<td>21.199</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hypotheses

The first and second hypotheses tested addressed how the Encourager Program affected personal well-being and predicted that personal well-being would increase after session 2 (mid) when compared to pretest ($H_{a1}$) and increase after session 3 (post) when compared to pretest ($H_{a2}$). The next two hypotheses tested how the Encourager Program affected spiritual well-being and predicted that after session 2, spiritual well-being would increase after session 2 (mid) when compared to pretest ($H_{a3}$) and increase after session 3 (post) when compared to pretest ($H_{a4}$). Finally, the last two hypotheses evaluated a Care Seeker’s church engagement and predicted that a Care Seeker would either remain involved, become involved, or increase church engagement after session 2 (mid) compared to pretest ($H_{a5}$), and after session 3 (post) compared to pretest ($H_{a6}$) as a result of the Encourager Program. Analysis showed significance levels and mean and included results of assumptions, alpha level, degrees of freedom, test statistic, and whether the alternate hypothesis was supported, partially supported or not supported at all. Certainly, a future researcher will want to examine these dependent variables when statistical power is achieved. Still, in spite of lack in statistical power, the meta-level analysis is reported to demonstrate the necessary steps needed for a successful analysis.
First Research Question. Is there an increase in personal well-being after session 2 (mid), compared to pretest, when a Care Seeker participates in the Encourager Program?

\( H_0^1 \): Personal well-being for a Care Seeker increases after session 2 (mid) of the Encourager Program, compared to pretest.

\( H_a^1 \): Personal well-being for a Care Seeker does not increase after session 2 (mid) of the Encourager Program, compared to pretest.

Although estimates showed an increase in Mean (\( M \)) in pwb at midtest (\( M = 40.48 \)) when compared to pretest (\( M = 35.72 \)), pairwise comparisons revealed that pwb was not statistically significant (\( p = .55 \)) overtime, reporting a mean difference of 4.77, 95% CI [-31.5, 31.5] between pre (time point 1) and mid (time point 2). The Encourager Program did not lead to any statistically significant difference in pwb at midtest when compared to pretest therefore, the researcher failed to reject the null hypothesis, rejected the alternate hypothesis, and concluded there was not sufficient evidence to show whether or not the mean difference remained the same overtime.

Second Research Question. Is there an increase in personal well-being after session 3 (post) compared to pretest, when a Care Seeker participates in the Encourager Program?

\( H_0^2 \): Personal well-being for a Care Seeker increases after session 3 (post) of the Encourager Program, compared to pretest.

\( H_a^2 \): Personal well-being for a Care Seeker does not increase after session 3 (post) of the Encourager Program, compared to pretest.

Again, pwb showed an increase of means at posttest (\( M = 40.48 \)), when compared to pwb at pretest (\( M = 35.72 \)). Mid and posttest mean were equal and pairwise comparisons reported that pwb also was not statistically significant (\( p = .55 \)) overtime, again reporting a mean difference of
4.76, 95% CI [-13.5, 23.0], \( p = .55 \)). Thus, for the second hypothesis, the Encourager Program did not have a statistically significant difference and the researcher failed to reject the null hypothesis, rejected the alternate hypothesis, concluding there was not enough evidence to support otherwise.

**Third Research Question.** Is there an increase in spiritual well-being after session 2 (mid), compared to pretest, when a Care Seeker participates in the Encourager Program?

\( H_{a3} \): Spiritual well-being for a Care Seeker increases after session 2 (mid) of the Encourager Program, compared to pretest.

\( H_{03} \): Spiritual well-being for a Care Seeker does not increase after session 2 (mid) of the Encourager Program, compared to pretest.

Question three asked if spiritual well-being would increase at midtest when compared to pretest. Estimates showed a decrease in swb when tested at pretest (\( M = 49.33 \)) to midtest (\( M = 49.00 \)). Pairwise comparisons reported that swb was not statistically significant (\( p = 1 \)) overtime, with a mean difference of -.33, 95% CI [-7.08, 6.41], \( p = 1 \). The Encourager Program did not increase swb, therefore the researcher failed to reject the null hypothesis, rejected the alternate hypothesis, and concluded there was not enough evidence to support otherwise.

**Fourth Research Question.** Is there an increase in spiritual well-being after session 3 (post) compared to pretest, when a Care Seeker participates in the Encourager Program?

\( H_{a4} \): Spiritual well-being for a Care Seeker increases after session 3 (post) of the Encourager Program, compared to pretest.

\( H_{04} \): Spiritual well-being for a Care Seeker does not increase after session 3 (post) of the Encourager Program, compared to pretest.
The fourth question also hypothesized there would be an increase in swb posttest when compared to pretest. While there was a further decrease in mean from pretest \((M = 49.33)\) to posttest \((M = 48.33)\), pairwise comparisons also showed no statistical significance \((p = 1)\) in swb in posttest compared to pretest overtime with a mean difference of -1, 95% CI \([-28.58, 26.58]\), \(p = 1\). The researcher failed to reject the null hypothesis, rejected the alternate hypothesis, and concluded there was not enough evidence to support otherwise.

**Fifth Research Question.** Is there a difference in church engagement after session 2 (mid), compared to pretest, after participating in the Encourager Program?

**Ha5:** A Care Seeker will remain, become involved or increase in church engagement after session 2 (mid) of the Encourager Program, compared to pretest.

**H05:** A Care Seeker will remain, will not become involved or increase in church engagement after session 2 (mid) of the Encourager Program, compared to pretest.

As previously mentioned in this chapter, the questions posed for ce were discussed in more detail as frequencies. Still, when frequencies were analyzed, it was noted that some qualitative observations were available (Table 2). The first question for ce was related to attendance and frequencies between pre and midtest showed that \(N = 3\) participants attended Hope less than 2 years, \(N = 1\) participant had attended 2-5 years and \(N = 1\) participant had attended 6-9 years. This did not change from pre to midtest however, and 2 participants did not complete the third session discussed further in the next question.

The second question was related to involvement and out of a possible 6 responses, three were common in ce_pre, ce_mid and ce_post: (1) Volunteer (i.e., Greeter, Next Steps, Usher, Children’s Ministry, choir, other), (2) Small Group, and (3) I would like more information (for complete responses see Table 2). Results showed that \(N = 2\) participants were involved in
volunteering, $N = 1$ participant was involved in small group, and $N = 2$ participants wanted more information on the above choices at pretest. It was interesting to note that at midtest, those who were volunteering remained at $N = 2$, but those who were engaged in small group increased by one ($N = 2$), and participants who wanted more information reduced by one ($N = 1$). This information is inconclusive, and inferences cannot be made as to why there was a change in small group participation due to the fact that $N = 2$ participants did not complete the third session, as well as the significant reduction in power analysis. Thus, the researcher failed to reject the null, rejected the alternate hypothesis and concluded there was not enough evidence to competently say whether or not there was a statistically significant difference in church engagement as a result of the Encourager Program at midtest when compared to pretest.

**Sixth Research Question.** Is there a difference in church engagement after session 3 (post), compared to pretest, after participating in the Encourager Program?

**$H_{a6}$:** A Care Seeker will remain, become involved or increase in church engagement after session 3 (post) of the Encourager Program, compared to pretest.

**$H_{06}$:** A Care Seeker will not remain, not become involved or increase in church engagement after session 3 (post) of the Encourager Program, compared to pretest.

The sixth hypothesis tested also presumed that a Care Seeker would either remain, become involved in or increase church engagement at posttest when compared to pretest. The same two questions were posed, and the results from the questions are recorded above in the 5th hypothesis. On the surface, since volunteering and small group participants remained the same at pre to posttest, one could make the assumption that the two participants who did not complete the third session were the same two participants indicated with missing information. However, there is no way to draw such a conclusion since participants were coded and not identified in this
study, thus reporting results in this instance were unfounded. Similarly, the researcher failed to reject the null, rejected the alternate hypothesis and concluded there was not enough evidence to competently say whether or not there was a statistically significant difference in church engagement as a result of the Encourager Program at posttest when compared to pretest

**Conclusion**

In light of a global pandemic that impacted sample size for Care Seekers who contacted the LIFE Center for biblical soul care, the researcher did not obtain the needed data for statistical power ($\beta = .50$). Still, results were put forth to inspire future researchers with a foundational methodology for more studies on church programs, as well as to demonstrate aptitude.

Again, the overall purpose of this study was to show whether or not a church program, provided in the context of the church, could make a statistically significance difference on personal well-being, spiritual well-being and church engagement. In the framework of a pilot study, the final chapter of this research paper will include a discussion on how the results reported above potentially support or contradict other studies and theories and how it sets the foundation for future research. Also found in chapter five are the implications of this report, its limitations and recommendations on how to improve upon what is presented in this study.
CHAPTER FIVE: CONCLUSIONS

Overview

The first four chapters of this study presented an introduction in chapter one, then an exploration of the literature in chapter two, followed by the type of design and methodology used to discover outcomes in chapter three. Then, in chapter four, the findings were presented as to whether or not the Encourager Program made a statistically significant difference on three constructs, personal well-being, spiritual well-being and church engagement. Although this investigation ended with a reduced sample size and limited final outcomes primarily due to a global pandemic still, the findings in chapter 4 presented a potential methodology that could help future researchers discover a sustainable technique to measure peer-to-peer biblical soul care church programs.

Future research on this topic offers the opportunity to provide empirically based results alongside other psychotherapeutic methodologies studied in the context of secular venues. The importance of strengthening the methodology to analyze church programs and continue on in gathering empirically based evidence is urgent, as it could potentially change the direction of the mental health crisis and is further emphasized in this final chapter. This chapter concludes this body of research beginning with discussion around each research question in light of the results, literature, other studies, and theory previously presented. Next, implications are presented with an intention to enthuse future researchers about the relevance and significance of this topic, and the need for future empirically based studies on church programs with a more robust sample size. A larger sample size could provide more substantial, scientifically based evidence which might cultivate value for community care and counseling. Next, limitations to this study are discussed as it relates to both internal and external validity, and any steps that should be taken to help limit
threats in future studies. Finally, recommendations for future researchers are presented on how to better design and enhance future studies on church programs that could demonstrate statistical significance. As well, this study will conclude with a direct call for pastors and church leaders to actively engage in developing church members through a deep biblical soul care methodology in the church in order to present the body of Christ as a validated, trusted forerunner in the mental health community.

Discussion

The overall purpose of this study was to investigate a specific gap in literature with regard to whether or not a peer-to-peer biblical soul care methodology, provided in a church setting, has a statistically significant impact on personal well-being, spiritual well-being and church engagement. Past research on this concept presented results on personal well-being and spiritual well-being in a variety of other contexts but did not include a focus on results from within the church (Tan & Scalise, 2016; Salwen, Underwood, Dy-Liacco & Arveson, 2017; Van Tongeren, 2019). The focus on results specifically for the impact on personal and spiritual well-being being when ministered to in the context of the church, could potentially enhance the existing body of research already well represented in other settings. Additionally, studies of this nature could theoretically substantiate future research as it relates to the efficacy in personal well-being, spiritual well-being and church engagement. The following narrative will reflect on these constructs through the lens of each research question in light of the results, literature, other studies and theory already discussed.

Personal Well-Being

In Chapter 2, titled “Literature Review”, personal well-being was discussed as a construct that helped bring understanding to a person’s overall quality of life. The Duke Health Profile –
Anxiety/Depression subscale (Duke University, 2020) was chosen as the instrument to determine the condition of a Care Seeker’s personal well-being at pre, mid and posttest, measured by the intervention of the Encourager Program would increase. As noted in chapter 2, the entirety of the Duke Health Profile (DHP) fully recognizes six different health measures – physical, mental, social, general, perceived health, and self-esteem; and four dysfunctional measures – anxiety, depression, pain, and disability (Parkerson, et al., 1990). Since no literature reflects outcomes on the status of personal well-being in the context of a church, the dysfunctional subscale, Anxiety and Depression (Duke-AD) consisting of 7 questions was operationalized and administered as a measure for personal well-being in a Care Seeker to help determine the impact the Encourager Program had at three levels. Two questions were asked of personal well-being (pwb) in this investigation, (1) is there an increase in personal well-being after session 2 (mid), compared to pretest, when a Care Seeker participates in the Encourager program, and (2) Is there an increase in personal well-being after session 3 (post) compared to pretest, when a Care Seeker participates in the Encourager Program?

Through a one-way repeated measures ANOVA, the first two hypotheses were tested and showed that pwb was not statistically significant different overtime as a result of the Encourager Program. The outcomes for the first two hypotheses led the researcher to retain the null, reject the alternate and conclude there was insufficient evidence to show that the means between levels of within-subjects’ factors would actually remain the same in the sample size overtime. Although the outcome showed no statistically significant difference, it is the slight increase in mean difference which leads the researcher to believe there is great value in future research on this subject. Since the more often reported result for pwb in other settings shows a statistically significant difference, the researcher believes that ideally in a larger sample size, which would
reduce a Type II Error, outcomes could indeed report a statistically significant difference in pwb overtime as a result of the Encourager Program as theorized in this study. Although this conjecture is noted with great caution, it still provides a strong argument for future researchers to continue in investigating and presenting scientifically validated outcomes in pwb when treated in the context of the church.

**Spiritual Well-Being**

Questions 3 and 4 asked whether or not spiritual well-being would increase at midtest when compared to posttest, and again at posttest when compared to pretest as a result of the Encourager Program. As well, spiritual well-being showed no statistically significant difference overtime, leading the researcher to retain the null, reject the alternate and conclude there was not enough evidence to prove either hypothesis. Although Mauchly’s test of sphericity showed a statistically significant difference \( (p = .047) \) in swb, tests of within-subjects effects showed the assumption of sphericity was met for swb \( (p = .93) \). Additionally, the mean difference and standard deviation decreased overtime a by total of 1.0 and .82 respectively.

Spiritual well-being tends to increase when interventions are applied in other settings (Jafari, Dehshiri, Eskandari, Najafi, Heshmati, & Hoseinifar, 2010; Unterrainer, Ladenhauf, Moazedi, Wallner-Liebmann, 2010; Velasco-Gonzalez & Rioux, 2013; Abu-Raiya, et. al., 2016; Salwen, Underwood, Dy-Liacco & Arveson, 2017). Although the data in this research was inconclusive, positive outcomes found in past research projects again leads the researcher to consider that in a larger sample size, as well as a post pandemic effect, outcomes would align with earlier research. To discover whether or not swb would indeed increase in a church setting, it could be beneficial for future researchers to employ this type of continual analysis and methodology.
Church Engagement

The final two questions in this analysis were related to church engagement. Again, two questions were asked, how long a Care Seeker had attended Hope Church and second, about the level of involvement as it related to volunteering, being in a small group or going on a mission trip. The initial intent was to produce quantitative measures to help assess whether or not the Encourager Program could provide a statistically significant difference in church engagement. At least two things were revealed post data collection. First, the responses for the questions in the Intake (pretest) and Feedback form (mid and pretest), were not written correctly in order to be scored effectively for quantitative outcomes showing any statistical significance. Second, a validated quantitative scale providing Likert type scoring, would better provide solid, empirically based outcomes. Regardless, the responses from the way the questions were presented in this study provided frequencies that could be useful in a more robust study.

Both questions were scored 1-5 and 1-6 respectively and provided outcomes into what type of trends would be possible with this type of data. For example, in a more robust sample size, a researcher might find a possible correlation between a Care Seeker’s attendance and involvement overtime. In this small sample size, it was noted that N of 1 indicated involvement in a small group at pretest and N of 2 showed involvement at midtest. As previously indicated, in no way does this provide evidence to support the additional participant’s involvement in small group at midtest was due to the intervention of the Encourager Program. However, it promotes asking the question of what might happen in a larger sample size. Recommendations for how to improve the church engagement responses to discover whether or not a church program could impact engagement is mentioned later in this chapter. Next, is a look at the implications this type of research could have on the mental health community as a whole.
Implications

The implications that could come from this type of methodology that tests how effective church programs might be in future research, could potentially enhance the care provided to those who are suffering mentally and emotionally in a more holistic, reparative approach. Regardless of the setting, most counseling approaches are pain-focused and bend toward providing techniques to help alleviate the pain (Crabb, 2005; McMinn, Staley, Webb, & Seegobin, 2010), rather than help transform a person from sufferer to victor (1 Corinthians 15:57). It is the researcher’s conviction, that the primary focus on pain-oriented solutions could be due to the misconceptions that exist between the church and the secular mental health community. This is not to be understood as a notion that the integration of psychology and Christianity is ineffective; it certainly is effective as well as empirically validated. In fact, integration theories have shown to greatly assist a person who seeks to grow in their faith and out of their pain (Sites, et. al., 2009). Still, the type of methodology presented in this study, could prove worthy of pursuit because of what it could mean as a way to offer assistance in supporting a healthier collaboration between the church and licensed professionals, as well as enhance relations between the two to facilitate trust. Churches who train members to come alongside those who are suffering, with a focus on transformation of the soul for a healthy connection in community could, over time, bridge the gap between the church and licensed professionals. While the results discussed in chapters 4 are not substantiated as statistically significant, the researcher supposes that outcomes in a larger sample size might prove otherwise thus, an urgency for further study into the predictions set forth in this research is needed.

Adding to the immeasurable amount of empirical evidence already provided in the professional mental health field on similar constructs, evidence-based church programs that care
for the soul through a theological lens, rather than immediately referring someone to professionals who treat the soul through a psychological lens (Charry, 2001), could immensely change the trajectory of mental health care and could span across many other disciplines including health care, public policy, criminal justice and other fields; but those are beyond the scope of this paper. Assessments of church programs are in desperate need to further evaluate whether or not this type of methodology could be of use in future research on the efficacy of biblical soul care. To provide a substantial analysis to impact the greater cause, there are limitations that must be addressed.

**Limitations**

There are limitations in every study and this one is no different. While many internal and external threats limited this study’s potential, below are three critical limitations noted to encourage future, worthwhile research. The first limitation discussed is the uncontrollable variable of the global pandemic, COVID-19. Second, is how sample size was directly impacted as a result of the pandemic. Then, the limitations that the use of the instruments put on valid outcomes are discussed.

**A Global Pandemic**

First, and probably most relevant, as it greatly impacted the second limitation, was the global pandemic that began at the time data collection began. While post COVID-19 mental illnesses have caused a substantial rise in many disorders including anxiety, depression, PTSD and other trauma related maladies (Vostanis, & Bell, 2020; Tucker & Czapala, 2021), at the start, calls into the LIFE Center from Care Seekers came to a complete halt at the start of stay-at-home orders, then began to slowly increase. Prior to COVID-19, the LIFE Center received 25-30 Care Seekers who participated in the Encourager Program each month for 2 or 3 sessions. In a 3-
month window, that average would have certainly provided the necessary sample size \( N = 56 \) for statistical power. Now, the current rise in disorders among pandemic survivors suggests there are not enough clinicians to care for those who are in crisis (Altiraifi & Rapfogel, 2020; Schwartz, Sinskey, Anand, & Margolis, 2020; Türközer, & Öngür, 2020). With that said, this body of research becomes an even stronger motivation to encourage further investigation into church programs and the need for trained peers in the church to step forward in preparation for the increased need of care. The results put forth from this type of methodology from such research as biblical soul care, could presumably withstand any potential scientific criticisms and petition renewed collaboration between the church and secular, mental health professionals.

**Sample Size**

Second, as previously mentioned, the pandemic and statewide closures had a significant impact on sample size and was greatly reduced. The request to conduct this research was admitted to the International Review Board (IRB) on March 20, 2020, around the time a global pandemic began taking hold of the world. As previously mentioned, this led to state orders for all but essential workers to stay at home in an attempt to mitigate the risk of spreading the virus (Robeznieks, 2020). As the United States economy experienced a sharp increase in unemployment, furloughs and layoffs, the state of the world being thrown into a stay-at-home status (Franco, 2020; Hosain & Rasel, 2020), had an impact on this study’s sample size, as calls from Care Seekers to the LIFE Center greatly reduced to zero in the first few months.

Additionally, mental health professionals and church care givers were scrambling to transition into what is now known as telehealth, providing counseling and peer-to-peer biblical soul care over secure, video-based platforms. The transition to Zoom for the LIFE Center provided the alternative for Encouragers and Care Seekers to continue meeting over a secure,
web-based platform with video and audio for counseling sessions. Secure video conferencing became a necessary tool for providing mental health services to those who were seeking help, both in the professional and church setting. As the months passed, a slight increase of phone calls resumed for those seeking care through the LIFE Center and Encouragers began meeting again. As it relates to the LIFE Center, data collection was designed to come directly from Care Seekers who self-initiated contact, leaving effectiveness to rely solely on participation. One recommendation, discussed in more detail later, would be to include a voluntary control group to help substantiate results.

**Use of Instruments**

*Duke-AD*. Another limitation discovered post data collection, was the implementation of the Duke-AD scale and church engagement questions. The scoring of the Duke-AD instrument was complex, describing a 3-step process by the authors of the instrument. In this study, additional steps were added as a result of not placing the instrument’s original values on the Intake and Feedback forms. What actually occurred and what should have occurred is described in this section.

The Duke-AD, a subscale on the Duke Health Profile (Parkerson, et. al., 1990), measured personal well-being as a test of anxiety and depression. As noted in chapter 2, from the instrument itself, researchers were instructed to take the last digit of the raw score from the 7 answers provided on the subscale. In the case of the Duke-AD subscale, Care Seekers answered items 4, 5 and 7 from the scale that asked: “I give up too easily”; “I have difficulty concentrating”; and “I am comfortable being around people”. Responses to choose from were the same for all three: “Yes, describes me exactly”, “Somewhat describes me”, and “No, doesn’t describe me at all”. The first two items (4 and 5) were scored as 40, 41 and 42, and 50, 51, 52.
The third question, item 7, was scored 72, 71 and 70. The next 4 statements were items 10, 12, 13 and 14 and all began with: “During the PAST WEEK, how much trouble have you had with: Sleeping, …Getting tired easily, …Feeling depressed or sad, …Nervousness”. The responses to choose from these 4 statements were: “None”, “Some”, or “A Lot” and were scored 102, 101, 100 for item 10; 122, 121, 120 for item 12; 132, 131, 130 for item 13; and 142, 141, 140 for item 14.

One of the limitations noted in this study stems from how the responses were written on the Intake and Survey Forms. On the Intake and Feedback forms, the above responses for all items were scored 1-3 for each. This brought about a fourth step in the process of transposing numbers versus the 3-step process given by the creators of the Duke-AD instrument. The Duke-AD instrument instructs the researcher to (1) write down the raw score, (2) write the last number of the raw score, then (3) revise the last number of the raw score as follows: If 0, change to 2; if 2, change to 0; if 1, no change. Since the questions on the Intake and Feedback forms were scored 1-3, the first additional step added to this process led the researcher to (1) record the original score from the Intake and Feedback forms, (2) convert the initial score to the raw score from the Duke-AD, and then implement the last two steps as mentioned above.

So, if a Care Seeker responded with “A Lot” for item 14, the researcher recorded 3 as the original score from the Intake and Feedback Form. Next, the researcher matched the response of 3 with the third response for item 14 on the Duke-AD instrument, the raw score of 140. Third, the last digit of the raw score, in this case 0, was recorded. Fourth, the last digit was revised as instructed and the raw score 0, was revised to a final score of 2. The final step to obtaining a total score for the anxiety/depression section of the Duke scale was to take the sum of the 7 revised scores and multiply them by 7.143. To illustrate this, the researcher puts forth the following
example for item 14 on the Duke-AD scale when the Care Seeker’s original response is “A Lot”, as written and shown in Figure 3. When a Care Seeker answered “A Lot”, the following steps were taken in Microsoft Excel®: (1) original score \( o = \text{original score} \) was matched with the raw score on Duke-AD scale; (2) the raw score \( r = \text{raw score} \) from the Duke-AD was noted; (3) the last digit \( ld = \text{last digit} \) was recorded in a separate column; (4) the final score \( fs = \text{final score} \) was recorded in a separate column, (5) then all final scores \( fs \) were summed \( s = \text{sum} \) and was multiplied by 7.143 for the final sum of scores for each Care Seeker. The step-by-step process is illustrated below:

**Figure 3**

*Illustration of Recoding for Duke-AD*

<table>
<thead>
<tr>
<th>Code</th>
<th>Original score ( (os) )</th>
<th>Raw score ( r )</th>
<th>Last digit ( ld )</th>
<th>Final Score ( fs )</th>
<th>Sum of scores ( S ) * 7.143</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>3</td>
<td>140</td>
<td>0</td>
<td>2</td>
<td>14.29</td>
</tr>
</tbody>
</table>

Step 1: Response on Intake Form (pre) is “A Lot”: \( os = 3 \)

Step 2: Raw score on Duke-AD scale: \( r = 140 \)

Step 3: Last digit of raw score is 0: \( ld = 0 \)

Step 4: Last digit of raw score revised to final score: \( fs = 2 \)

Once all final scores \( fs \) are summed, the researcher is then instructed to multiply the sum of scores \( S \) by 7.143 to provide the ordinal data used to provide final analysis for statistical significance. The formula below includes a subscript number to represent each item on the Duke-AD scale:

\[
\text{Final Step: } fs_4 + fs_5 + fs_7 + fs_{10} + fs_{12} + fs_{13} + fs_{14} = S*7.143
\]
When the items were incorporated into the Intake and Feedback forms, the extensive process illustrated was not taken into account. Scoring the items as (1) Yes, describes me exactly; (2) Somewhat describe me; (3) No, doesn’t describe me at all for all 7 items on the Intake and Feedback forms led to various levels of translation, which were completed by hand in a Microsoft Excel® spreadsheet, as shown above. The 4-step process in this instance was complicated, but more easily implemented due to the small sample size ($N = 5$). This process would have been a much greater undertaking had the sample size been larger, increasing the potential for error during data screening and entry. Recommendations for future researchers are to use the original scoring on the Duke-Ad, eliminating additional steps and the potential for error.

**Church Engagement.** Another potential limitation was the construction of the church engagement responses which provided frequencies versus quantitative results. The intent of the church engagement questions, designed by the Director, were to capture empirical data to gauge a Care Seeker’s church involvement, specifically as it relates to small group, going on a mission trip or serving as a result of the Encourager Program. The two questions asked were, “How long have you been a member at Hope Church?” and, “If you are attending, or are a member of Hope Church, are you involved in or connected with any of the following areas of service? (State all that apply). Responses were scored 1-5 and 1-6 respectively and were as follows: (1) I do not attend Hope Church; (2) Less than 2 years; (3) 2-5 years; (4) 6-9 years; (5) 10+ years. Then, for the second question the responses were: (1) Volunteer (i.e., Greeter, Next Steps, Usher, Children’s Ministry, Choir, other); (2) Small Group; (3) I have been on a mission trip; (4) I would like more information about going on a mission trip; (5) I would like more information on connecting in one or more of the above; and (6) None of the above.
The limitation to the above two questions was quickly realized post data collection since the above responses provided more frequencies, rather than nominal data with a quantitative perspective to a Care Seeker’s involvement in the church as a result of the Encourager Program. Again, recommendations as to the benefit of providing empirical outcomes on church engagement as a result of church programs is discussed later in the next section.

**Recommendations**

The final section of this project introduces recommendations to assist future researchers in designing a solid, empirically sound methodology and defense for church programs as a viable solution that could better cooperate with the mental health community for those who are hurting. As well, the researcher puts forth a direct call to trained church leaders to become active in monitoring the efficacy of soul care programs provided in their church by capturing up to date data for analysis. The overall ambition in this study was to demonstrate whether or not a church program, administered as a stand-alone resource for those who are suffering in a church setting, could demonstrate a statistically significant difference in similar constructs already validated in the mental health community and other arenas. Undergirding the overarching ambition, was the desire to bring attention to more of a collaboration between the church and mental health communities as an additional option for helping the hurting.

While there were great limitations that threatened the internal and external validity of this work, success was found in presenting this work as a pilot study that has the potential to support a sound methodology for further examination of church programs. The recommendations discussed in this section first relate to strengthening design and methodology, followed by recommendations for achieving a robust sample size. Third, correct use of instrumentation, specifically how to correct the use of the Duke-AD scale, and reconstruction of the church
engagement questions or use of another scale all together. Finally, a summary and a specific call for churches to engage more directly is provided to conclude this research project.

**Strengthening Design and Methodology**

The design of this study was a quasi-experimental design, set to determine whether or not a peer-to-peer methodology could have a significant, quantitative impact on constructs primarily measured in clinical settings. This body of research became a pilot study, mostly due to its small sample size as a result of the global pandemic that occurred at the start of data collection. Additionally, not being more of an experimental design with a control group contributed to the exploratory nature of this study. Still, this analysis provided the basis to a strong argument for a concentrated effort toward the use of this type of methodology for future investigations to test church programs for scientific reliability. As a first step, future researchers could improve upon the design for this type of research by adding a control group and random selection for a more experimental design; provided it brings no harm (ACA, 2014; AACC, 2014) to the Care Seeker. Caution is advised in having a control group in this type of investigation due to Care Seekers potentially having to delay biblical soul care for the hurt they are experiencing.

Even so, the intent of the study could be explained, providing Care Seekers the option to be a part of the treatment group or control group. In this way, the researcher would continue intake until power analysis is achieved in both groups to ensure valid outcomes. Having a control group gives evidence as to whether or not the independent variable does in fact matter when it is absent (Warner, 2013; Laerd Statistics, 2021). Holding the Encourager Program, or other church program, constant over the control group for the same 8-week period as for the treatment group, allows for stronger validity and a more robust investigation that could withstand the rigors of scientific validation. Again, the caution to including a control group is the potential to further
harm a Care Seeker as they receive no treatment for a period of three to eight weeks. One advantage of the Encourager Program is that if there were a waiting list, and the Care Seekers met weekly as designed, at worst, the wait time would be 8 weeks, the time period assigned for this study; at best, the wait time would be 3-4 weeks. It is certainly worth exploring how to implement an experimental design and methodology that could add to the vast amounts of empirically researched outcomes in the mental health community.

A second step to improve methodology could be to bring great clarity to an enhanced, operational definition and understanding of biblical soul care to help in the approach of church programs being administered by trained peers and reduce stigma as it relates to counseling and mental illness. The historical tension between science in the church, whether it is an either/or argument, or an integration/separation argument, has arguably caused a great deal of divergence, unnecessary, territorial disputes within the field of mental health, and possible harm to those seeking care. The researcher is of the opinion, and agrees with McMinn and Phillips (2001), when they put forth the idea of viewing people-helping strictly through the lens of having to choose between, “Christ or Freud”, is detrimental to the overall community of mental health. Providing great clarity around what is psychotherapeutic help and what is biblical soul care could potentially lead to healing the distrust between two communities, equally needed on both sides, for the holistic care of a person. One should not isolate knowledge that comes by human revelation from salvific knowledge, or vice versa (Jones, 2001). Instead, a clear understanding of what each revelation is designed to provide could better serve the ones who matter most, those who are hurting.

Human revelation has great value in serving those who suffer with maladies such as anxiety or depression, and there are effective modalities that are essential and effective in
helping to manage pain (Jones, 2001). What a secular modality cannot accomplish, and was never meant to accomplish, is bridging the gap between the soul and God; only Jesus can do that. Jesus has called His own people to administer the soul healing He has for others (Tan & Scalise, 2016). A collaborative approach to counseling and soul care is the dominating thought in this research as another option that, when given the proper attention and consistent scientific pursuit, could allow for a greater health in the client or Care Seeker, and relational health within the community of care givers on both sides of the aisle.

**Sample Size**

The shutdown caused by the pandemic previously discussed certainly hindered data collection during the time of this research. Although transition to administering biblical soul care through the Encourager Program was accomplished, awareness of the availability of Encouragers could have been greatly improved early on. Understandably, it took the church staff time to adjust in the beginning of transitioning home, but as the online audience grew, so did the effectiveness of communicating what ministries were available to those who were watching online. By the time a banner that said, NEED CARE OR COUNSELING – TEXT 94090 was fully implemented, this study was closed, and the researcher proceeded with the 5 participants available. One change that has occurred in the use of Zoom is how the reach of the Encourager Program has greatly expanded to those who are hurting beyond the walls of the church, and even the city of Las Vegas. It is highly recommended that continued use of a secure video conferencing platform remain a part of a peer-to-peer biblical soul care program offered through the church.

A second set back to sample size to note, is the known fact that not all Care Seekers completed all three sessions. In this specific study, there were a total of $N = 5$ participants, an $N$
of 3 completed all three sessions and an $N$ of 2 completed two sessions. If that 40% ratio were to play itself out in a sample size of $N = 56$, there could have been $N = 34$ who completed all three sessions and $N = 22$ who completed two sessions. While that would have provided a larger sample size reducing Type I and Type II errors, effect size would have still been at risk. An overall recommendation is to pursue similar studies on church programs on a consistent basis to achieve a strong power analysis.

**Correct Scoring of Instrumentation**

Recommendations for the Duke-AD and church engagement instruments involve correct implementation and reconstruction of questions. The Duke-AD scale showed good reliability and validity while administered in other settings thus, the researcher believes it to be a good instrument to use in evaluating a church program. It is not encumbered with a large number of questions and when scored correctly, provides accurate, quantitative outcomes to help understand whether or not a church program, such as the Encourager Program, could make a statistically significant difference in personal well-being. While the Duke-AD is an appropriate scale to measure personal well-being, the researcher recognized the need for better implementation and clearer instruction on how to score the results and implement analysis. As well, church engagement was intended to give quantitative outcomes from a two-question survey, designed by the researcher of this paper. The following will provide a clear, step-by-step process for use of the DHP-AD instrument and recommendations for reconstructing the current church engagement questions or searching out another instrument.

*Duke Health Profile – Anxiety and Depression (Duke-AD)*. As detailed earlier in the section on limitations in this chapter, when data was collected and input into Microsoft excel, the process became cumbersome as additional levels of translation were manually implemented to arrive at
the instructed outcome. Rather than the 5-step process the researcher conducted by hand in Microsoft Excel®, which increased the risk for error, future researchers could apply the original values presented on the DHP-AD scale directly to the Intake and Feedback forms. Using the example earlier on item 14, the actual raw score from the DHP scale of “140” could be placed next to the corresponding statement. The number 140 should have no impact on the participants response since the numbers are not explained on the survey but simply represent scores for the researcher. This allows for the researcher to more easily follow the instructions from the scale, reduce error, and allow for a more accurate analysis during data entry.

**Church Engagement.** The recommendation for church engagement is to reconstruct the questions to provide quantitative results. The first question, “How long have you been at Hope?” can still be a helpful question with the understanding at the start, it would be descriptive in nature and gives nominal data that could provide correlations between the length of time Care Seekers are at the church and how much they are involved. The second question however, “If you are attending, or are a member of Hope, are you involved in or connected with any of the following areas of service?” could indeed produce a quantitative measure by breaking up the response for volunteering into individual choices, then rank score the responses. The response option for the second question could then be as follows: (1) Greeter, (2) Next Steps, (3) Usher, (4) Children’s Ministry, (5) Choir, (6) Small Group, (7) I would like more information on joining a small group (8) I have been on a mission trip, (9) I would like more information about going on a mission trip, and (10) None of the above. The researcher could then revise the above data points as follows: None = 0; one choice = 1; two or more choices = 3.
Conclusion

The intentions of this study were grand. The great deficiency in quantitative research that stem directly from church programs administered by trained peers, is potentially one of the greatest hinderances to achieving a healthier, more trusting, collaborative effort between the church and mental health professionals. This lack has lent itself as the driving force for this work. The researcher seeks to advance the need for adding scientific validity to the church’s role in caring for the souls of those who are in crisis. As a front-line resource for those who seek care, the church has cause for soul care givers to rise to the occasion, to biblically care for those who are hurting, and partner with those in the professional field in a more holistic way. In that way, the student beseeches pastors to create the type of culture that quickens the hearts of those who sense a call into soul care ministry and raise up strong leaders to provide right training. A biblically and theologically focused type training that keeps peers who administer biblical soul care through a selected church program rooted in the Great Commission Jesus gave to all those who follow Him to, “go therefore and make disciples” (Matthew 28:19). As disciples make disciples, the student believes that healed disciples help make healed disciples.

Furthermore, to earn respect and regain trust between the church and the mental health community, it could be strongly argued that the church has a responsibility to validate the type of soul care they provide. Not because Christ or grace needs validation, but so the church community can establish a scientific base to match the base already validated in the mental health community. Indeed, further studies on church programs has become a great necessity, not even by choice but by force, as the option of the client or Care Seeker to seek out the church first, as a front-line resource now places the initial burden of response on the church. There are matters that are more in need of soul healing, which only Christ can provide, rather than
psychological healing, that only a trained clinician ought to provide. Dr. Larry Crabb (2005) speaks directly to this matter when he writes,

Those matters that need to be confessed, the secrets we harbor and the internal struggles we endure in our never-ending fight against sin, have been removed from church community and taken to the counselor’s office. When we long to make ourselves known to someone who could represent Christ to us, when we look for a wise, caring person who will hear us and open us up with love rather than shut us down with rules or clichés, the few we find in the church (if we find anyone at all) are typically unavailable. So, we turn to professionals, to people trained in “therapeutic relating” who are available because they make a living being available.

We’ve come to a time in our culture when therapists have been asked to take over the functions formerly handled by priests, a function that properly belongs to biblical elders who listen because they’ve had the courage to listen to their own hearts, to face what’s bad and discern the Spirit, who can speak powerfully into the lives of others because they hear Christ speak powerfully into their lives.

Where are the people who can listen well and guide us through our problems to the Father’s heart and who regard it as their calling to do so? (Crabb, 2005, p. 96-97).

As Dr. Crabb (2005) notes in this poignant statement from his important work, Connecting, the church has a responsibility to provide biblical soul care to those who reach out, in the only way a trained peer who believes in Jesus can. A strong argument is made in this work for the urgent need of continued, academically driven investigations on pure, peer-to-peer biblical soul care, above all because God has called His church to dispense His grace and encouragement to those who are in distress. This is not and cannot be the work of a secular psychologist. The cause here is paramount since research provides evidence that the church is the first point of contact for those who are suffering. Investigations with this type of methodology made a priority in the mental health community, could potentially provide the scientific results respected by researchers and mental health professionals. The academic responsibility is then to bring quantitative measures to biblical soul care for the benefit of creating a healthy
collaboration with the mental health profession. This exploratory type study became the impetus to build strong, trusting alliances with mental health professionals, especially in a post pandemic world where maladies are already on the rise (Türközer, Öngür, 2020). Such research could heighten the urgency within those who are called to do the work of biblical soul care in the context of the church to rise up and become a part of the solution to help move a sufferer to victor on their journey in Christ.


Ortberg, J. (2014). Soulkeeping: Caring for the most important part of you. Zondervan: Grand Rapids, MI.


LIFE Center

Foundations Training

Creating a safe place to HEAL, DISCOVER and THRIVE
Welcome to LIFE Center Foundations

The LIFE Center exists to create a safe place to **HEAL** from life’s hurts, **DISCOVER** an intimate relationship in Christ and **THRIVE** as a Jesus follower. One of the ways we help those who are hurting, or who just need some direction, is through the Encourager ministry.

Paul writes in 1 Thessalonians 5:9-11 (NLT)

*For God chose to save us through our Lord Jesus Christ, not to pour out his anger on us. Christ died for us so that, whether we are dead or alive when he returns, we can live with him forever. So, encourage each other and build each other up, just as you are already doing.*

Also, in Hebrews 3:13 (NASB), we are told,

*But encourage one another day after day, as long as it is still called “today,” so that none of you will be hardened by the deceitfulness of sin.*

This course is designed to help you become acclimated to the LIFE enter, it’s story, its purposes and its mission; as well as equip you to come alongside those who are hurting as an encourager. You will find that your decision to join this training will be more about your own soul well-being than it is about you learning techniques to help others. There is the practical side of coming alongside those who are hurting, but more importantly, the relational development that will occur between you and Jesus will determine your growth as you help those who are hurting.

*The best thing you can ever bring into [any helping relationship] is your own personal relationship with Christ.*

-Vance Pitman

(but referring to marriage)

The following is the schedule for our time together:

**Week 1** | Introduction – Encourager Training Session 1
**Week 2** | Encourager Training, Part 2
**Week 3** | Encourager Training, Part 3
**Week 4** | *Connecting* by Larry Crabb – Chapters 1 & 2 | Reading/Discussion
**Week 5** | *Connecting* by Larry Crabb – Chapters 9 & 10 | Reading/Discussion

Weeks 4 & 5’s reading and discussion will revolve around *Connecting* by Larry Crabb (book provided). You are encouraged to begin reading in week 1 as we will discuss parts of this book, not the whole to facilitate our conversations.

I am honored to have you as part of this training and I am praying for God to ground you in Him, His Word, His will and all His ways.

**Blessings,**

Michelle D. Dickens
LIFE Center Director
Encourager Training
Session 1 – Katie Walters

1 One day Peter and John were going up to the temple at the time of prayer – at three in the afternoon.

2 Now a man who was lame from birth was being carried to the temple gate called Beautiful, where he was put every day to beg from those going in and out of the temple.

3 When he saw Peter and John about to enter, he asked them for money.

4 Peter looked straight at him, as did John. Then Peter said, “Look at us!”

5 So, the man gave them his full attention, expecting to get something from them. – Acts 3:1-5

Encouragers is a 3-session model based on Acts 3:1-5:

1. STORY
2. TRUTH
3. NEXT STEP

STORY

1. Do not enter the session looking to change someone but to __________ someone.

2. The goal of this level of counsel is to give people an ____________________________.

3. Stories are ____________________________.
4. We want to communicate 3 basic things:
   a. _______________________
   b. _______________________
   c. _______________________

Something you can say during your first session – STORY:
“This is a 3-session process and during this first meeting all I’m going to do is listen to your story. I’m going to listen with one ear to you and one ear on God asking him for a word of encouragement. This is a safe place for you to share with me and everything you say here is kept here. You can start anywhere you like, but this time is yours. “

Three things that must be present during this first session – STORY:
   a. People need to know they are SAFE
   b. People need to know they are HEARD
      i. Active listening has three parts:
         1. Eye Contact
         2. Body Language
         3. Reflective Listening
   c. People need to know they are LOVED
5. The goal of this first session is simply: ________________________________

6. Only GOD can teach people how to ________________ and ________________
   tough times.

   If you will be willing, God will do the rest. He has chosen you!

**Answer Key:** (1) Love; (2) encounter with Jesus; (3) sacred; (4a) safe; (4b) heard; (4c) loved; (5) that they come back; (6) suffer and endure
Encourager Training
Session 2 – TRUTH

If we are not careful in the way we ________________ (1) and ________________ (2) to people, it makes it harder for them to accept the ____________ (3) they need to hear.

The word became flesh and made his dwelling among us. We have seen His glory of the one and only, who came from the Father, full of grace and truth.
– John 1:14

All of us are doing the best we can with what we have.

Have you ever met an abuser that wasn’t an ________________ (4) themselves?
Have you ever met a yeller that wasn’t an ________________ (5) themselves?

We have come to know and believe the love which God has for us.
God is love, and the one who abides in love abides in God, and God abides in Him. – 1 John 4:16

In childhood, the ________________ (6) shapes the inside. In adulthood, the ________________ (7) shapes the outside.

___________ % (8) of the issues we deal with in our adult life are rooted in our childhood.

Most people don’t need you to tell them that what they are doing is ________________ (9).

What they need is someone that will ________________ (10) them enough and ________________ (11) them and help them figure out how to ________________ (12).
FILTER OF GRACE

3 KEY Factors:

1. ________________________ (13) & Multi-generational predisposition
   (Deuteronomy 5:9).

   Sin means the _____________ (14) or performing the deed.

   Iniquity means to be _________________________ (15) or leaning toward the act or deed.

2. Early Life ________________________ (16)

   Imprint = ________________________________ + ________________________________ (17 & 18)

   Most imprints are in place by age __________ (19)

3. Our Life ________________________ (20) as we grow

   If you can ______________ it, you can ____________ it. If you can’t
   ______________ it, you can’t ______________ it. (21-24) Romans 6:16

What we live we ________________________ (25)
What we learn we ________________________ (26)
What we practice we ________________________ (27)
Discussion Questions

What do you know about your genetics; and how do you relate that to who you are?

How do early life imprints impact you?

What life choices have you made that led you to where you are now in life?

**Answer Key:** (1) carry ourselves; (2) respond; (3) truth; (4) abuser; (5) yell; (6) outside; (7) inside; (8) 80-90%; (9) wrong; (10) love; (11) come beside; (12) stop; (13) Genetic; (14) act; (15) bent; (16) imprints; (17) experience; (18) strong emotion; (19) 7; (20) choices; (21, 23) choose; (22, 24) change; (25) learn; (26) practice; (27) become
Encourager Training
Session 3 – TRUTH

Grace means mercy in ____________________________ (1) or action.

*If you love me, you will keep my commands.*
– John 14:15

*I do not understand what I do. For what I want to do I do not do, but what I hate I do.*
– Romans 7:15

*Beloved, I wish above all things that thou mayest prosper and be in good health, even as thy soul prospereth.*
– 3 John 2
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<td><strong>GENESIS 1-2</strong></td>
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**Then the Lord God formed man of the dust of the ground and breathed into his nostrils the breath of life; and man became a living soul.** - Genesis 2:7 (KJV)

**And the very God of peace sanctify you wholly and I pray God your whole spirit and soul and body be preserved blameless unto the coming of our Lord Jesus Christ.** – 1 Thessalonians 5:23 (KJV)

Man was created spirit, \___________, and body
Adam’s spirit possessed the life and breath of God.

His soul possessed the knowledge of the truth which was the knowledge of God and
His \___________

The two, his spirit and soul, functioned in complete harmony.

The spirit was the master, the soul served the spirit, and the body served the soul.

The spirit communed directly with God and ‘enlightened.”

The spirit \___________
Itself through the soul and the soul expressed itself through the body.

Man is still made up of spirit, soul, and body.

The spirit is now \___________ or separated from God. Death definition; fall out of \___________ with.

The soul is cut off from the knowledge of the truth, which is the knowledge of God and His ways.

The two, his spirit and soul, now function in complete disharmony.

The \"\___________\" soul now rules our lives.

(Reference: Watchman Nee)

Soul = mind, will & emotions.

The soul is \___________ and must be reeducated in knowledge of God and His ways.

“**And do not be conformed to this world but be transformed by the renewing of your mind.”** - Romans 12:2 (NASB).

“...and that you be renewed in the spirit of your mind.” Ephesians 4:23 (NASB).

The two, the spirit and soul, do NOT automatically function in harmony.

The “exalted soul” will continue to dominate if allowed to do so.

The \___________ \___________

developed prior to salvation must be pulled down.

The spirit still must express itself through the soul and the soul through the body.

John 3:3, 5-6 (NASB)

Man’s spirit is \___________ in the image and likeness of Jesus.

Direct fellowship with God is potentially restored.

The Holy Spirit indwells the believer and guides us into all truth.

The soul = mind, will & emotions.

Destructive patterns of thought belief and behavior develop deep within the soul it’s a definition of a stronghold. - 2 Corinthians 10:4 (KJV),

“**Heart \___________**
are formed and become the guiding force to all decisions.

**Be it unto you according to your faith.** - Matthew 9:29 (KJV).

The spirit expresses itself through the soul & the soul expresses itself through the body.

**Answer Key:** (1) motion | soul; ways; expresses | dead; correspondence; exalted; beliefs | made; unchanged; strongholds
Encourager Training
Session 4 – Speaking TRUTH in Love

When someone reaches out to you, it may be the ________________ (1) thing that they have ever done.

____________________ (2) and ________________________ (3) are important but they are not enough to get people through the challenges in their life.

We have to be willing to introduce ____________________________ (4) in people’s lives.

We have to be willing to _____________________________ (5) those moments from God and introduce TRUTH into people’s lives.

____________ (6) isn’t grace if there is no _____________ (7).

Answer Key: (1) bravest; (2) Empathy; (3) compassion; (4) TRUTH; (5) lean into; (6) grace; (7) truth
Encourager Training
Session 5 – Next Steps

Life change happens in the context of ________________________________ (1)

At the close of Session 2, when God has given you a word of truth, ask the care seeker to pray.

If they have done this, then you are just ________________________________ (2).

If they have not done this, then you can ________________________________ (3) for ________________________________ (4)

Paths available to care seekers in Hope Church (will be answered after video):

1. ________________________________ (5)

2. ________________________________ (6)
   a. ________________________________
   b. ________________________________
   c. ________________________________
   d. ________________________________
   e. ________________________________ (by invitation only)

3. ________________________________ (7)

4. ________________________________ (8)
Encourager literally means to impart ___________________________ (9)

This Encourager session is not for you to ___________________________ (10) the next step for them, but to ___________________________ (11) the discussion of what they’re discerning is their best ___________________________. (12).

**Something you can say during your second session to set up session 3:** *So the next time we are together will be our last session. This model is meant to be a very short-term model because we believe the best-case scenario of life change happens in the context of a group where you get to share other people’s pain and have more of an example of real community.*

*But this week I simply want you to ask God, ‘God what are you saying and what am I going to do about it?’*

**Questions you can ask:**

1. Ask them about the ___________________________ (13)?
   This will begin to help discern their motivation behind what they are wanting to do.

2. Consider the amount of ___________________________ (14) this is going to be for the person you’re meeting with to take a next step.

3. Remember, it’s God who does the ___________________________ (15).
   Care, but not ___________________________ (16).

**Answer Key:** (1) community; (2) discerning; (3) pray together; (4) God’s direction; (5) Small Groups; (6) Support Groups – (a) DivorceCare (b) Financial Peace University (c) GriefShare (d) Health & Strength (e) STEPS; (7) Biblical Counseling (8) Serving; (9) courage; (10) prescribe; (11) facilitate; (12) next step; (13) Why; (14) courage; (15) work; (16) carry
The preferred and quicker method of communication is via text or email. If you have a question or need to set a time to discuss something, please text or email and I will respond within 24 hours.

I. Description

This one year Biblical Counseling training gives participants an opportunity to consider what it is to offer Biblically based, pure, peer-to-peer counseling, grounded in the context of the church, with the purpose of connecting others to live the life of a Jesus follower. It will provide a safe and creative space to explore one’s motives, heart and call into the ministry of soul care.

The goal is to equip participants to be effective in their call to minister to those who are hurting via Biblically based guidance, compassionate care, as well as empathetic and active listening. The training will also train participants to make proper referrals, when needed. It will clarify the specific distinction between pastoral care, peer-to-peer (also known as lay) counseling, and licensed professional care so as not to blur the lines in a well thought out soul care ministry to those who are hurting. The participant will learn to give God’s direction in a short-term, solution-focused manner so that care seekers can become a part of community in a healthy way.

II. Rationale

There is a great deal of confusion in the world of counseling. To bring clarity to that, the primary focus for this one-year training is to ground participants into what pure, Biblical peer-to-peer counseling, in the context of the church really means. It will give simplicity to what it means to collaborate with licensed professionals, rather than...
integrate secular methods into the Biblical Counselor, care seeker relationship. When the church is the church, doing what God called His bride to do – make disciples – there is no confusion, and care seekers can begin a healthy journey in healing their heart, mind, soul and strength.

III. COURSE CONTEXT

This course is designed with the ministry and DNA of Hope Church in mind, providing soul care through the care ministry of the LIFE Center. This is not a college or certificate program. This is an in-house training to strengthen the current Biblical Counsel team, and to help others, who are called, provide Biblical direction (discipleship) to others, while growing in their own personal relationship with Jesus.

The demand on the church to provide care for, and/or offer proper referrals to those who are hurting and/or are in crisis is increasing. It is now reported that those in distress are more likely to seek out a member of the clergy than they are a professional – 85% or more (Stanford, 2016). The goal of this course is to help participants understand how to offer a safe place, for those who are hurting, to begin the journey to HEAL from life’s hurts, DISCOVER an intimate relationship in Christ, and THRIVE as a Jesus follower, so that, they can then ABIDE in Christ, CONNECT in community and SHARE in the mission locally and globally.

In Christ, God’s people have the ability to live a healthy, 5% Life (GOD Time, GATHER Time, GROUP Time, GO Time) in community with other believers where real-life change occurs, and in the world in which they live, work, and play. This course will help participants connect care seekers to live the life of a Jesus follower in the way God means for them to, so they can participate in the larger picture of the Kingdom.

*It takes a certain kind of person to swim in the pain of the world and not get wet.*

(quote from 911 television episode 1, season 1)

IV. REQUIRED RESOURCE PURCHASE(S):

Courage and Calling by Gordan T. Smith
Becoming the Me I Want to Be by John Ortberg
Replenish by Lance Witt
Soul Keeping by John Ortberg
Connecting by Larry Crabb
Solution-Focused Pastoral Counseling by Charles Allen Kollar
Additional Resources:


V. ADDITIONAL MATERIALS FOR LEARNING

A. Computer with basic audio and video capabilities
B. Internet access (broadband recommended)
C. Microsoft Word

VI. MEASURABLE LEARNING OUTCOMES

Upon successful completion of this training, participants will be able to:

A. Communicate a clear and distinct understanding of what pure peer-to-peer counseling in the context of the church means.
B. Have the ability to identify, but not treat, certain symptoms of those needing physiological and clinical care so that proper referrals can be provided.
C. Provide solution-focused, short-term care that is Gospel centered to care seekers in a safe, non-judgmental environment.
D. Effectively connect people to live the 5% life as a Jesus follower.

VII. COURSE REQUIREMENTS AND ASSIGNMENTS

A. COURSE REQUIREMENT CHECKLIST

As the first activity in this course, those attending will participate in an on-line basic theological questionnaire as a way to gauge understanding of basic theology. **The results must be printed by participant and brought to first class in order to continue on in the training.**
B. CL **ASS** **INTRODUCTIONS**

Each participant will introduce him/herself to the other classmates in the first session, that includes the following information:

i. How long has he/she been a member at Hope?

ii. What is his/her role in the LC?

iii. What, if any, other areas of ministry do he/she serve in?

iv. Why does he/she want to take this class?

v. What does he/she expect to learn in this class?

vi. Something interesting most may not know about him/her (i.e., hobby, favorite movie, a bucket list item)

C. **BOOK REVIEW ASSIGNMENTS**

**1st Semester (due the last week of semester)**

Participant will read selected chapters from both, but select between *Courage and Calling* by Gordan T. Smith or *Becoming the Me I Want to Be* by John Ortberg for a book review and complete a 1–2-page (double-spaced) review that includes:

1. An overall summary of a selection that impacted you.

2. A point, theme or idea in the text the participant really connected with and explain the connection in a personal way.

3. How, if at all, the selected text has changed the participant’s perspective, or what new idea or area the participant gained knowledge.

4. How the participant will apply the above information, specifically as it relates to helping care seekers.

**2nd Semester (due last week of semester)**

Participant will select between *Soul Keeping* by John Ortberg or *Replenish* by Lance Witt for a book review and complete a 1–2-page (double-spaced) review that includes:

1. An overall summary of a selection that impacted you.

2. A point, theme or idea in the text the participant really connected with and explain the connection in a personal way.

3. How, if at all, the selected text has changed the participant’s perspective, or what new idea or area the participant gained knowledge.

4. How the participant will apply the above information, specifically as it relates to helping care seekers.
D. CLASS SCHEDULE

1st Semester | (Feb 1 – Apr 5, 10 weeks)

Facilitators: Michelle Dickens

Material:
* Becoming the Me I Want to Be* by John Ortberg
* Courage and Calling* by Gordan T. Smith

Caring for People God’s Way Video Curriculum:
- Becoming a Christian Counselor – BCOU101
- The Effective People Helper – BCOU201

Agenda:
Feb 1  Week 1: Introduction and Biblical Foundations | Michelle

Feb 8- Mar 1  Weeks 2-5: Becoming the Me I Want to Be | Michelle
  Week 2: Read Part One (Chapters 1 & 2)
  Week 3: Read Part Two (Chapters 3-6)
  Week 4: Read Part Five (Chapters 15-18)
  Week 5: Read Part Six (Chapters 19-21)

Mar 8-Mar22  Weeks 6-8: *Courage and Calling* (book provided) | Michelle
  Week 6: Read Chapter 1
  Week 7: Read Chapters 5 & 8
  Week 8: Read Chapters 10 & 12

Mar 29  Week 9: Becoming a Christian Counselor – BCOU101

Apr 5  Week 10: Using Your Spiritual Gifts in Counseling – BCOU102

2nd Semester | (Apr 19 – Jun 28, 11 weeks)

Facilitators: Michelle Dickens, Pastor Teddy Johnson, Pastor Jeff Phillips

Material:
* Replenish* by Lance Witt
* Soul Keeping* by John Ortberg

Agenda:
Apr 19  Week 1: Introduction | Michelle

Apr 26  Week 2: Significance of Abiding | Pastor Jeff
May 3-May 17  Week 3-5: Replenish and Significance of Self Care | Michelle  
Week 3: Read Introduction (Chapters 1-3)  
Week 4: Read De-Toxing Your Soul (Chapters 4-11)  
Week 5: Read Sustaining a Spiritual Life  
(Chapters 23-25, 28-31, Epilogue)

May 24  Week 6: Healing through Worship | Pastor Teddy

May 31  NO CLASS | MEMORIAL DAY

Jun 7-28  Weeks 7-10: Soul Keeping | Michelle  
Week 7: Read: pp 13-48 (Intro, Prologue, Chapters 1-2) | Michelle  
Video Session 1 shown in class  
Week 8: Read: pp 49-78 What the Soul Needs (Chapters 3-5) | Michelle  
Video Session 3 shown in class  
Week 9: Read: pp 81-125 (Chapters 6-10) | Michelle  
Week 10: pp 126-176 (Chapters 11-15) | Michelle

3rd Semester | Fall (Aug 2 – Oct 25, 13 weeks)  
Facilitators: Michelle Dickens

Material:  
Connecting by Larry Crabb  
Solution-Focused Pastoral Counseling by Charles Allen Kollar

Agenda:

Aug 2  Week 1: Introduction | Michelle

Aug 9-Aug 30  Week 2-5: Connecting | Michelle  
Week 2: Read: Introduction, Chapters 1-3  
Week 3: Read: Chapters 4 & 5  
Week 4: Read: Chapters 8 & 9  
Week 5: Read: Chapters 10, 13 & 14

Sep 6  NO CLASS | LABOR DAY
Sep13-Oct25  Week 6-12: Solution-Focused Pastoral Counseling | Michelle
   Week 6: Read: pp 9-42 (Intro, Chapters 1-4)
   Week 7: Read: Chapter 5, 6, 7
       (How do we create solutions, pp 41-42, teach this)
   Week 8: Read: pp 89-122 (Chapters 8-10)
   Week 9: Read: pp 123-156 (Chapters 11-12)
   Week 10: Read: pp 157-178 (Chapters 13-14)
   Week 11: Read pp 181-206 (Chapters 15-16)
   Week 12: Conclusion | Michelle (Video: Diane Langberg)

TBD       BCT Graduation Ceremony | Details to follow

VIII. COURSE EXPECTATIONS
   A. Participants are expected to attend all classes in order to pass with the exception of emergencies and illness.
   B. Participants will be allowed to miss a total of 3 classes in the year, outside of the above mentioned in “A”. If more than 3 are missed, participant will be required to make up the missed classes in their own time in order to be a Biblical Counselor in the LIFE Center.
   C. It is expected that all material will be read, and participants will actively engage in learning and sharing what God is showing them during each class.
   D. All homework is expected to be complete in order to pass.

COURSE GRADING – THIS IS A PASS OR FURTHER DEVELOPMENT NEEDED GRADING.
APPENDIX C: PERMISSION TO USE SPIRITUAL WELL-BEING SCALE

On Jun 20, 2017, at 8:05 PM, Ray Paloutzian <paloutz@westmont.edu> wrote

Michelle,

Now I see what you mean. Yes you can set the computer system (Survey Monkey or equivalent secure system) so that you give your form and the SWBS in sequence (is what it sounds like) so that the match is automatic. Sure. The SWBS has to have the same copyright line as on the paper copy, but the scale is the scale and I have made arrangements of this sort for people to use an online procedure many times.

May your dissertation research go totally glitch-free!

Ray

On Jun 20, 2017, at 7:06 PM, Dickens, Michelle <mdickens10@liberty.edu> wrote:

Dear Ray, thank you VERY MUCH for your reply. I apologize for the miscommunication on my part. By filling out two separate forms I meant the intake form with a few questions we have for ourselves and then the SWB that you provide. We send a wufoo form to begin intake and ask pertinent questions. I would then receive that and match them with an Encourager. I was hoping to combine your form with mine, and I’d be happy to integrate survey monkey!

I understand and I do apologize for lacking in better explanation on my part! I so appreciate your help and am excited to further the studies for your scales!

Michelle

________________________________________
Michelle D. Dickens
Cell: (702) 217-2602
www.FaithMadeGenuine.com

And you must love the LORD your God with all your heart, all your soul, all your mind, and all your strength. ~Mark12:30

Sent from my iPhone

On Jun 20, 2017, at 9:52 PM, Ray Paloutzian <paloutz@westmont.edu> wrote:

Michelle,

I don’t know what is meant in your query copied below by saying that the subject won’t have to take two separate items. The SWBS has 20 items that comprise two subscales. But they are combined into one 20-item scale for ease of administration. If you mean that you don’t wish that the participants have to complete two separate scales (and by that you are referring to the RWB and EWB subscales) — they fill them out as one scale with 20 items. After that, you score the EWB and RWB separately in order to see how the scores come out for EWB and RWB, and then sum those to get total SWB. You probably will want to get the manual that is indicated on the website — it explains these things, precise scoring instructions, and so forth. RE electronic submission, see below and see the manual. It is OK to put the SWBS on an electronic site so long as it is password protected and the only people who access it are your research subjects. (Many people use, e.g., Survey Monkey to do this.) After data collection is completed, remove it from the site. The cost for administration of an electronic version of the SWBS is the same per administration as the cost for authorization to make paper copies. Payment is made the same way for the same N on the LifeAdvance.com website. I hope this helps. What follows is my standard email to those who ask various questions about the SWBS. —Ray P.
Below I copy and paste a long email that I send in response to the many requests I get about the SWBS. No doubt you know a lot of it already, but it may have a few bits of info that might help you. Also, attached is a chapter published in an Oxford textbook that is the most recent review of SWBS research. May be useful. Here is the info.

Permission is granted to use the SWBS subject to purchase of the number of copies (i.e., authorization to make the number of copies from a PDF file that you download) that you will use. See the website www.lifeadvance.com. It has information about the scale and the instructions to follow to obtain the Specimen Set that includes one examination copy of the scale, the manual for the SWBS that includes scoring instructions, norms, interpretive information, and a research bibliography. (For student research, a student is authorized to use the student discount procedure, which will give a 50% discount on all items.) When you go to the products page of the website, select the icon that indicates the number of copies of the scale that you are purchasing authorization to make from the PDF download that you retrieve after processing your order. You will see on the Products Page that the cost per copy goes down as the N goes up, in steps of 50. After you select the icon that corresponds to your number of copies, you will go to the shopping cart page. Change the number to the correct number for your purchase and then punch the “update shopping cart button.” Then follow the procedures, collect the PDF file download as indicated on the web page (or on the email that is also sent to you), and you are thereby authorized to make and use the number of copies that you purchased authorization to make.

See the chapter by Paloutzian et al. published in the Oxford Textbook of Spirituality in Healthcare, edited by Cobb et al. This chapter is the latest statement on the topic. I have attached this chapter to this email.

Data Analysis: If you plan on doing statistical analysis on scale scores: One thing that I always recommend is to analyze your data not only according to the SWBS total scores, but also according to the RWB and EWB subscale scores separately, in addition to the total SWBS scores. Of course total SWBS is made up of RWB + EWB. Fine. But RWB and EWB correlate only modestly, which is why they are two separate factors. And sometimes the RWB and EWB scores behave differently from each other, and not exactly the same as the behavior of the SWBS total. This means that looking at those two subscales can tell you something psychologically interesting that the SWBS total score cannot do by itself, i.e., it allows you to dig deeper. So I strongly recommend that you look at your data and do the same analyses all three ways. See the review paper by Bufford, Paloutzian, and Ellison 1991 as a nice example of how the scores can be meaningfully broken down in this way.

Translations: If you need to make a translation of the SWBS from English into another language, contact me and I am able to authorize it. The website has translations into Chinese, Arabic, Spanish, Portuguese, Norwegian, Malaysian, Persian, English Childhood Retrospective, Korean, Cebuano, Tagalog, Turkish, and Indonesian.

Electronic administration: It is OK to use the SWBS electronically with, e.g., Survey Monkey or similar. In this case, 1 electronic administration of the scale equals 1 paper copy of the scale, so (for example) if you have an electronic N = 100, the cost is exactly the same as for 100 paper copies. The website has to be protected so that only your authorized subjects have access to it, the scale cannot be copied or emailed or otherwise distributed, the copyright line should show electronically, and the scale should be removed from the website at the close of data collection.

In addition, you may find it helpful to see the 2nd edition of Paloutzian and Park (2013) Handbook of the Psychology of Religion and Spirituality, 2nd ed., Guilford Press. It as a chapter on religion and spirituality, measurement of R and S, and other topics that may be related to your needs. (Also, it is available in paperback for only about $40 USD.) Also see Paloutzian, R. F. (2017), Invitation to the Psychology of Religion, 3rd ed., Guilford Press. Paperback.

Thank you,

Ray Paloutzian (Ray)

On Jun 20, 2017, at 12:36 PM, Michelle Dickens <noreply@jotform.com> wrote:

This contact form was sent from lifeadvance.com. Please respond accordingly.
<table>
<thead>
<tr>
<th>Name</th>
<th>Michelle Dickens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email</td>
<td><a href="mailto:mdickens10@liberty.edu">mdickens10@liberty.edu</a></td>
</tr>
<tr>
<td>Subject</td>
<td>Use of SWB Electronically</td>
</tr>
</tbody>
</table>

**Message**

Hello! I am a doctoral student at Liberty University and came across your SWB Scale. I would love to use this measurement as a part of my dissertation with the care seekers I currently serve in the church I attend. I am the Director of the LIFE Center at Hope Church in Las Vegas, NV.

We have an electronic (on-line) intake form and I would like to know if I could receive permission to transcribe the 20-item SWB scale into our electronic intake document so that those who are seeking help will not have to complete two separate items?

Or, if there is a way to access this electronically through purchase, then I could insert the link to it?

Thank you so much for your consideration.

Michelle Dickens  
Ph: 702-217-2602  
E: mdickens10@liberty.edu
APPENDIX D: INTAKE FORM

LIFE Center Intake Form

GENERAL INFORMATION
[Please answer the following questions honestly and accurately. Please note that there are multiple pages. Each question must be saved before going to the next one. A response is required for each question before the survey can be submitted.]

Name:
Age Range:
[ ] (1) 18-25 yrs
[ ] (2) 26-33 yrs
[ ] (3) 34-41 yrs
[ ] (4) 42-49 yrs
[ ] (5) 50-57 yrs
[ ] (6) 58-64 yrs
[ ] (7) 65+ yrs

Male or Female
[ ] (1) Male
[ ] (2) Female

Cell Phone (this will allow us to notify you of confirmed appointment times and reminders through text):
Best time to call:
[ ] Morning
[ ] Evening

What is the best time and day during the week for you to meet with an Encourager? (Check all that apply):
[ ] Morning
[ ] Afternoon
[ ] Evening
[ ] Monday thru Friday
[ ] Weekends

How long have you attended Hope Church? (You do not have to attend Hope to meet with an Encourager or Biblical Counselor):
[ ] (1) I do not attend Hope Church
[ ] (2) Less than 2 years
[ ] (3) 2-5 years
[ ] (4) 6-9 years
[ ] (5) 10+ years
If you are attending, or are a member of Hope, are you involved in or connected with any of the following areas of service? (State all that apply)
(1) Volunteer (i.e., Greeter, Next Steps, Usher, Children’s Ministry, Choir, other)
(2) Small Group
(3) I have been on a mission trip
(4) I would like more information about going on a mission trip
(5) I would like more information on connecting in one or more of the above
(6) None of the above

How did you hear about the LIFE Center?
(1) Referred by a friend
(2) Referred by a professional
(3) Website
(4) Social Media
(5) Taken to LIFE Center table after one of the Gather services
(6) Other (If other, please explain in the space below)

INFORMATION REGARDING YOUR REQUEST
The following information will help us connect you with the best person. Thank you for inviting us to walk with you through your journey. We are not licensed counselors or psychiatrists. We offer encouragement and Biblical Counsel directly from the Word of God. Please fill in the information below and an Encourager will contact you within 2-3 business days.

Describe in one or two sentences the reason for your call. Please be as specific as you can:

Have you spoken to someone about the same situation mentioned above?

If yes, what was the advice you were given at that time?

On a scale of 1-10 (1 meaning non crisis; 10 meaning crisis) rate your current situation. (NOTE: If this is an emergency, please call 911)

PERSONAL WELL-BEING (Duke Anxiety-Depression Scale)
(Copyright © 1994 -2017 by the Department of Community and Family Medicine, Duke University Medical Center, Durham, N.C., U.S.A.)

Please select ONLY ONE choice. You will also receive this questionnaire after your 2nd and 3rd session with your Encourager.

1. I give up too easily
   [ ] (1) Yes, describes me exactly
   [ ] (2) Somewhat describes me
   [ ] (3) No, doesn't describe me at all
2. I have difficulty concentrating
   [ ] (1) Yes, describes me exactly
   [ ] (2) Somewhat describes me
   [ ] (3) No, doesn't describe me at all

3. I am comfortable being around people
   [ ] (1) Yes, describes me exactly
   [ ] (2) Somewhat describes me
   [ ] (3) No, doesn't describe me at all

4. During the PAST WEEK how much trouble have you had with sleeping
   [ ] (1) Yes, describes me exactly
   [ ] (2) Somewhat describes me
   [ ] (3) No, doesn't describe me at all

5. During the PAST WEEK how much trouble have you had with getting tired easily
   [ ] (1) Yes, describes me exactly
   [ ] (2) Somewhat describes me
   [ ] (3) No, doesn't describe me at all

6. During the PAST WEEK how much trouble have you had with feeling depressed or sad
   [ ] (1) Yes, describes me exactly
   [ ] (2) Somewhat describes me
   [ ] (3) No, doesn't describe me at all

7. During the PAST WEEK how much trouble have you had with nervousness
   [ ] (1) Yes, describes me exactly
   [ ] (2) Somewhat describes me
   [ ] (3) No, doesn't describe me at all

SPIRITUAL WELL-BEING (Spiritual Well-Being Scale)
(SWB Scale © 1982 by Craig W. Ellison and Raymond F. Paloutzian. All rights reserved. Not to be duplicated unless express written permission is granted by the authors or by Life Advance. See www.lifeadvance.com.)

Please select ONLY ONE choice. You will also receive this questionnaire after your 2nd and 3rd session with your Encourager.

1. I don't find much satisfaction in private prayer with God
   [ ] (1) Agree
   [ ] (2) Moderately Agree
   [ ] (3) Strongly Agree
   [ ] (4) Disagree
   [ ] (5) Moderately Disagree
   [ ] (6) Strongly Disagree
2. I don't know who I am, where I came from, or where I'm going
   [ ] (1) Agree
   [ ] (2) Moderately Agree
   [ ] (3) Strongly Agree
   [ ] (4) Disagree
   [ ] (5) Moderately Disagree
   [ ] (6) Strongly Disagree

3. I believe that God loves me and cares about me
   [ ] (1) Agree
   [ ] (2) Moderately Agree
   [ ] (3) Strongly Agree
   [ ] (4) Disagree
   [ ] (5) Moderately Disagree
   [ ] (6) Strongly Disagree

4. I feel that life is a positive experience
   [ ] (1) Agree
   [ ] (2) Moderately Agree
   [ ] (3) Strongly Agree
   [ ] (4) Disagree
   [ ] (5) Moderately Disagree
   [ ] (6) Strongly Disagree

5. I believe that God is impersonal and not interested in my daily situations
   [ ] (1) Agree
   [ ] (2) Moderately Agree
   [ ] (3) Strongly Agree
   [ ] (4) Disagree
   [ ] (5) Moderately Disagree
   [ ] (6) Strongly Disagree

6. I feel unsettled about my future
   [ ] (1) Agree
   [ ] (2) Moderately Agree
   [ ] (3) Strongly Agree
   [ ] (4) Disagree
   [ ] (5) Moderately Disagree
   [ ] (6) Strongly Disagree
7. I have a personally meaningful relationship with God
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

8. I feel very fulfilled and satisfied with life
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

9. I don't get much personal strength and support from my God
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

10. I feel a sense of well-being about the direction my life is headed in
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

11. I believe that God is concerned about my problems
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree
12. I don't enjoy much about life
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

13. I don't have a personally satisfying relationship with God
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

14. I feel good about my future
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Disagree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

15. My relationship with God helps me not to feel lonely
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

16. I feel that life is full of conflict and unhappiness
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree
17. I feel most fulfilled when I'm in close communion with God
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

18. Life doesn't have much meaning
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

19. My relationship with God contributes to my sense of well-being
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

20. I believe there is some real purpose for my life
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

While your situation may not be resolved at the end of 3 sessions, as that is not the goal at this time, do you feel there could be hope and that you will be able to take the next step?
Select any of the following words that best describe you now. NOTE - PLEASE MAKE SURE YOU CLICK TO SAVE YOUR ANSWER after you have chosen all of the words that best describe you. This question does not automatically save your answers.

[ ] Active
[ ] Ambitious
[ ] Self-confident
[ ] Sensitive
[ ] Nervous
[ ] Hard-working
[ ] Impatient
[ ] Impulsive
[ ] Often blue
[ ] Excitable
[ ] Imaginative
[ ] Calm
[ ] Serious
[ ] Shy
[ ] Easy-going
[ ] Good-natured
[ ] Introvert
[ ] Extrovert
[ ] Moody
[ ] Quiet
[ ] Determined
[ ] Submissive
[ ] Likable
[ ] Lonely
[ ] Dramatic
[ ] Self-conscious
[ ] Leader
[ ] Other

Did you check "other" in the previous question? If yes, please explain:

Have you come to the place in your spiritual life where you know for certain that if you were to die today you would go to heaven? If yes, please explain (a Yes is not required to receive care):

After you complete and submit your survey(s), click on the 'My Counseling' tab to request counseling. In that screen, you will be asked to describe the specific problem(s) for which you desire counseling. **Your request is not entered into the queue until this last step is completed.**

Please initial in the space below, then request counseling under 'My Counseling Tab'
Encourager Feedback Survey

Thank you for taking time to provide feedback regarding your experience with an Encourager from the LIFE Center. It is valuable to us and helps us look at ways to improve how we encourage and connect people to live the life of a Jesus follower!

This form goes directly to the LIFE Center Director and Encourager/Counsel Team Leader. I WILL NOT see your responses. Feel free to provide any information that you feel went well, and that could have made your experience better.

I am grateful to have had the opportunity to hear your story and will continue praying for God's will and direction in your life.

First Last Name *
Age Range
Male or Female
Email *
Name of Encourager: *

RESPONSE TIME
On a scale of 1 to 10 (1 being extremely dissatisfied; 10 being extremely satisfied), rate the following:

How pleased were you with the time it took for someone from the LIFE Center to make first contact? *

How pleased were you with the time it took for an Encourager to make first contact? *

How long have you attended Hope Church? (You do not have to attend Hope to meet with an Encourage for Biblical Counselor): *
(1) I do not attend Hope Church
(2) Less than 2 years
(3) 2-5 years
(4) 6-9 years
(5) 10+ years

If you are attending, or are a member of Hope, are you involved in or connected in any of the following of service? (Check all that apply) *
(1) Volunteer (Greeter, Usher, Next Steps, Children's Ministry Choir, other)
(2) Small Group
(3) I have been on a mission trip
(4) I would like more information about going on a mission trip
(5) I would like more information on connecting in one or more of the above areas
(6) None of the above
Personal Well-Being
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The following questions are the same questions you answered on your Intake Form and are to assess if your time with an Encourager has helped in anyway.

1. I give up too easily
   [ ] (1) Yes, describes me exactly
   [ ] (2) Somewhat describes me
   [ ] (3) No, doesn't describe me at all

2. I have difficulty concentrating
   [ ] (1) Yes, describes me exactly
   [ ] (2) Somewhat describes me
   [ ] (3) No, doesn't describe me at all

3. I am comfortable being around people
   [ ] (1) Yes, describes me exactly
   [ ] (2) Somewhat describes me
   [ ] (3) No, doesn't describe me at all

4. During the PAST WEEK how much trouble have you had with sleeping
   [ ] (1) Yes, describes me exactly
   [ ] (2) Somewhat describes me
   [ ] (3) No, doesn't describe me at all

5. During the PAST WEEK how much trouble have you had with getting tired easily
   [ ] (1) Yes, describes me exactly
   [ ] (2) Somewhat describes me
   [ ] (3) No, doesn't describe me at all

6. During the PAST WEEK how much trouble have you had with feeling depressed or sad
   [ ] (1) Yes, describes me exactly
   [ ] (2) Somewhat describes me
   [ ] (3) No, doesn't describe me at all

7. During the PAST WEEK how much trouble have you had with nervousness
   [ ] (1) Yes, describes me exactly
   [ ] (2) Somewhat describes me
   [ ] (3) No, doesn't describe me at all
Spiritual Well-Being
(SWB Scale © 1982 by Craig W. Ellison and Raymond F. Paloutzian. All rights reserved. Not to be duplicated unless express written permission is granted by the authors or by Life Advance. See www.lifeadvance.com.)

The following questions are the same questions you answered on your Intake Form and are to assess if your time with an Encourager has helped in anyway.

1. I don't find much satisfaction in private prayer with God
   [ ] (1) Agree
   [ ] (2) Moderately Agree
   [ ] (3) Strongly Agree
   [ ] (4) Disagree
   [ ] (5) Moderately Disagree
   [ ] (6) Strongly Disagree

2. I don't know who I am, where I came from, or where I'm going
   [ ] (1) Agree
   [ ] (2) Moderately Agree
   [ ] (3) Strongly Agree
   [ ] (4) Disagree
   [ ] (5) Moderately Disagree
   [ ] (6) Strongly Disagree

3. I believe that God loves me and cares about me
   [ ] (1) Agree
   [ ] (2) Moderately Agree
   [ ] (3) Strongly Agree
   [ ] (4) Disagree
   [ ] (5) Moderately Disagree
   [ ] (6) Strongly Disagree

4. I feel that life is a positive experience
   [ ] (1) Agree
   [ ] (2) Moderately Agree
   [ ] (3) Strongly Agree
   [ ] (4) Disagree
   [ ] (5) Moderately Disagree
   [ ] (6) Strongly Disagree
5. I believe that God is impersonal and not interested in my daily situations
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

6. I feel unsettled about my future
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

7. I have a personally meaningful relationship with God
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

8. I feel very fulfilled and satisfied with life
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

9. I don't get much personal strength and support from my God
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree
10. I feel a sense of well-being about the direction my life is headed in
   [ ] (1) Agree
   [ ] (2) Moderately Agree
   [ ] (3) Strongly Agree
   [ ] (4) Disagree
   [ ] (5) Moderately Disagree
   [ ] (6) Strongly Disagree

11. I believe that God is concerned about my problems
    [ ] (1) Agree
    [ ] (2) Moderately Agree
    [ ] (3) Strongly Agree
    [ ] (4) Disagree
    [ ] (5) Moderately Disagree
    [ ] (6) Strongly Disagree

12. I don't enjoy much about life
    [ ] (1) Agree
    [ ] (2) Moderately Agree
    [ ] (3) Strongly Agree
    [ ] (4) Disagree
    [ ] (5) Moderately Disagree
    [ ] (6) Strongly Disagree

13. I don't have a personally satisfying relationship with God
    [ ] (1) Agree
    [ ] (2) Moderately Agree
    [ ] (3) Strongly Agree
    [ ] (4) Disagree
    [ ] (5) Moderately Disagree
    [ ] (6) Strongly Disagree

14. I feel good about my future
    [ ] (1) Agree
    [ ] (2) Moderately Agree
    [ ] (3) Strongly Disagree
    [ ] (4) Disagree
    [ ] (5) Moderately Disagree
    [ ] (6) Strongly Disagree
15. My relationship with God helps me not to feel lonely
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

16. I feel that life is full of conflict and unhappiness
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

17. I feel most fulfilled when I'm in close communion with God
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

18. Life doesn't have much meaning
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

19. My relationship with God contributes to my sense of well-being
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree
20. I believe there is some real purpose for my life
[ ] (1) Agree
[ ] (2) Moderately Agree
[ ] (3) Strongly Agree
[ ] (4) Disagree
[ ] (5) Moderately Disagree
[ ] (6) Strongly Disagree

On a scale of 1 to 10 (1 being extremely dissatisfied; 10 being extremely satisfied), rate how satisfied you were with the encouragement you received:

Was your Encourager on time to your first meeting? *

Did your Encourager provide a warm welcome? *

Did your Encourager ask if it was okay to open your time with prayer? *

Did your Encourager allow you the time you needed to share your story? (Meetings are to be 1 hour, so your answer should be based on that time frame). *

Was your Encourager engaged in your conversation? *

Do you feel like you were heard in this first meeting? *

In the second session, did your Encourager provide insight from the Bible and/or personal life examples relevant to your situation? *

In the third session, did you and your Encourager come up with a satisfactory next step? *

What was the next step you and your Encourager determined was best for you? *

While your situation may not be resolved, as that is not the goal at this time, do you feel there is hope and that you are able to take the next step?
(1) Yes (2) No

Overall, how would you rate your experience? *

Is there anything else you would like to explain or inform us of regarding your experience with your Encourager and the LIFE Center? (max 300 words)