EVANGELICAL MENTAL HEALTH DURING A PANDEMIC:

A THREE-WAY INTERACTION ANALYSIS

By

Michael S. Williams

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

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APPROVED BY:

Fred Volk, Ph.D., Committee Chair

Dwight Rice, D.Min., Ph.D., Committee Member

ABSTRACT

COVID-19 quickly became a global pandemic and a biological disaster. Mental health deteriorated due to fear, stress, isolation, and loneliness. Symptoms of anxiety, depression, stress, and disturbed sleep have been associated with COVID-19. There is limited research on mental health and well-being among evangelical Christians. A primary concern is that church congregants and leaders are tired and struggle with mental health issues. Thus, care for the congregation and community is limited. The rate of distress and depression among the religious is on the rise. The purpose of this quantitative research is to evaluate the interaction of perceived stress and emotional intelligence on the relationship between perceived social support and mental health among evangelical church members in the United States during the COVID-19 pandemic. The Mental Health Scale-Short Form, Multidimensional Scale of Perceived Social Support, Trait Emotional Intelligence Questionnaire-Short Form, and the Perceived Stress Scale were used in a statistically significant moderated moderation. Overall, the study contains substantial implications for counseling research and treatment planning.

Keywords: COVID-19, mental health, emotional intelligence, social support, stress

Dedication

Proverbs 3:5-6 reads, “Trust in the Lord with all your heart and lean not on your own understanding; in all your ways submit to Him, and He will make your paths straight” (NIV). First, I dedicate this research to my Lord and Savior Jesus Christ. Praise be to God for granting me the capability and capacity to pursue you and complete this valuable research. God’s grace is sufficient, even in my weaknesses.

Secondly, I want to dedicate this research to my wife and best half, Charity. Your unfailing love and unending support is a priceless gift. Yes, Beautiful, your name says it all.

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Table of Contents

List of Tables

List of Figures

List of Abbreviations

SARS-CoV-2 (COVID-19)

World Health Organization (WHO)

Southern Baptist Convention (SBC)

Southern Baptist Denomination (SBD)

Centers for Disease Control and Prevention (CDC)

Mental Health Scale-Short Form (MHC-SF)

Multidimensional Scale of Perceived Social Support Scale (MSPSS)

Trait Emotional Intelligence Questionnaire-Short Form (TEIQue-SF)

Perceived Stress Scale (PSS)

Statistical Package for the Social Sciences (SPSS)

CHAPTER ONE: INTRODUCTION

Overview

The purpose of this chapter is to discuss various areas of this research study. The background, problem statement, purpose statement significance of the research, research questions, and critical definitions are included. The introduction will highlight the problem, provide a possible solution, and reveal research gaps that this study addresses.

Background

COVID-19, a global pandemic, has infected more than 80 million people and is responsible for over 900,000 deaths in the United States (World Health Organization [WHO], n.d.). Physical health is not the only concern with this virus. Mental health has continued to deteriorate due to fear, stress, isolation, and loneliness (Czeisler et al., 2020; Levers, 2012; Sapolsky, 2004). COVID-19 was associated with social distancing, lockdown restrictions, and quarantine expected to have marked and enduring mental health effects (Coppola et al., 2021; Czeisler et al., 2020; Daly et al., 2021). Currently, variants, like the Delta and Omicron variants, are beginning to impact people globally (Alexander et al., 2021; WHO, n.d.).

Evangelicals and the Southern Baptist denomination are not immune to the impacts of the virus. Despite these challenges, little has been written about the Southern Baptist Convention (SBC), Southern Baptist Denomination (SBD), evangelicalism, and mental health. For example, there are over 435,000 local congregations and 14 million members in the SBD (Smietana, 2021). Unfortunately, the church, congregants, and financial numbers continue to decline due to a myriad of challenges (Smietana, 2021). This is surprising because mental health has been significantly impacted during the COVID-19 pandemic (Coppola et al., 2021; Czeisler et al.,

2020; Daly et al., 2021). There are scant studies on the topic of mental health in the denomination.

Mental health is the presence of emotional well-being and high levels of social functioning (McGaffin et al., 2015). In the United States, one out of every five people have a mental disorder in a given year, and at least 450 million people have a mental health issue worldwide (Stanford, 2021). Every year, one in five adults in the United States experiences mental illness (Shaw et al., 2021). Moreover, mental unhealth may continue to be one of the primary issues during and following the COVID-19 pandemic (Coppola et al., 2021; Czeisler et al., 2020; Daly et al., 2021; Winkler et al., 2020).

Mental illness was an issue among other pandemics as well. Mental health issues were raised during smallpox, plagues, Ebola, influenza, and HIV outbreaks (Janssen, 2021). Like COVID-19, these pandemics benefitted from a Christian response to improve mental health (Janssen, 2021). Messages of hope contained specific perspectives during the pandemics. Overall, churches encouraged people through compassion and teaching about how God creates, redeems, heals, and restores (Southgate, 2021). Healthier mental resilience during previous pandemics, and COVID-19, was derived from robust social support and intrapersonal stability (Vicini, 2021). Unfortunately, many people with mental illness during COVID-19 were isolated and self-preserved rather than having the ability to help others (Vicini, 2021).

Amid a mental health crisis due to the COVID-19 pandemic, few people live the abundant life Jesus promised (John 10:10). People can be restored and renewed in Jesus, who provides perfect peace. John 16:33 reads, "I have told you these things, so that in Me you may have peace. In this world you will have trouble. But take heart! I have overcome the world" (NIV). As the person becomes more like Jesus, the body of Christ can align with His mission

(Matthew 28:18-20; Mark 12:30-31). God desires his people to flourish mentally (I Corinthians 2:16; Philippians 4:8). To flourish in mental health, people must join God in His redemptive work (James 2:26). The local church, the body of believers, can become an extension of God's peace in the world (I Corinthians 12:12-14; Erickson, 2013; Köstenberger, 2010). The problem is that decreasing mental health impacts a local congregation's ability to minister effectively to one another or the community.

Evangelicals can become an extension of God's peace in the world (I Corinthians 12:12-14; Erickson, 2013; Köstenberger, 2010). There are mental health concerns among evangelicals and Southern Baptist church members during the COVID-19 pandemic (Czeisler et al., 2020; Daly et al., 2021; Wissing et al., 2021). Mental health concerns include anxiety, depression, stress, and grief (Czeisler et al., 2020; Daly et al., 2021; Eisma, 2020; Ettman et al., 2020; Giuntella et al., 2020; Gunnell et al., 2020; Harms et al., 2017; Kujawa et al., 2020; Simon et al., 2019; Zhai & Du, 2020). A gap exists in the literature understanding the extent and strength of mental health among evangelicals and Southern Baptists during the COVID-19 pandemic. Despite researched mental health challenges associated with COVID-19, little has been written about evangelicalism, SBC, SBD, and mental health in research or denominational publications.

This research sought an answer to cease the decline of mental health among evangelicals. Research has stated that higher levels of perceived social support have improved mental health during COVID-19 (Grey et al., 2020). Also, higher emotional intelligence has been shown to improve mental health and strengthen perceived social support (Malinauskas & Malinauskiene, 2020). Even though stress has increased during COVID-19, higher emotional intelligence and perceived social support may help decrease perceived stress levels (Malinauskas & Malinauskiene, 2020; Thomas & Barbato, 2020). More research needs to be completed on the

effects of stress as it interacts with emotional intelligence, perceived social support, and mental health.

Gaps in current research include mental health analysis among Southern Baptists as affiliated with evangelicalism; studying mental health, perceived social support, emotional intelligence, and perceived stress among Southern Baptists and evangelicals; researching COVID-19 and variants impact on Southern Baptist mental health; the use of quantitative research with the before mentioned variables; and the application of a moderated moderation study using the secondary moderation interaction of perceived stress. Mental health, perceived social support, emotional intelligence, and perceived stress have been significantly understudied concerning evangelicals and Southern Baptists, especially in quantitative analyses.

Problem Statement

Not only were people fearful of the physical adverse effects from COVID-19, but the pandemic also created spiritual, emotional, mental, social, and economic problems that impacted the home, church, school, businesses, and communities (Coppola et al., 2021). Amid these challenges, one of the direct losses of the Christian community was the ability to meet on campus and worship God corporately (Bryson et al., 2020). Worship services were transported digitally into people's homes (Bryson et al., 2020). Consequently, the secular and sacred experienced blended problems amid isolation, fear, frustration, and a lack of togetherness (Bryson et al., 2020). Local churches have been compelled to adapt like restaurants, schools, sporting venues, public transportation, and doctors' offices (Pillay, 2020). Local congregations may be in an uncomfortable conundrum while facing worship, missional, and theological shifts, especially since Southern Baptists as a whole reject change, as noted by the continued decline (Cagle, 2021; Pillay, 2020; Smietana, 2021).

The problem of the global pandemic is not finished (WHO, n.d.). The local evangelical congregation will find it necessary to adapt to fulfill the mission of making more and better followers of Jesus (Matthew 28:18-20). Division continues in evangelical denominations like the SBD among autonomous local churches (Cagle, 2021). Pastors in the United States and beyond were being as creative as possible to continue to share the love of God and encourage people amid fear, anxiety, stress, and hopelessness (Afolaranmi, 2020). Pastoral care and ministry transitioned from in-person on a church campus to online platforms like social media, websites, streaming services, and teleconferencing (Afolaranmi, 2020; Bryson et al., 2020). Little has been written about the ministry of the congregants of the local church. This could have been difficult to measure due to lockdown and social distancing orders (Afolaranmi, 2020; Coppola et al., 2021; Czeisler et al., 2020; Daly et al., 2021). More quantitative research is needed in mental health among Southern Baptists and holistically evangelicals in the United States since mental health is an issue during the COVID-19 pandemic.

People reported lower levels of perceived spiritual well-being during COVID-19 than before the pandemic (Coppola et al., 2021). Church leaders were challenged mentally, emotionally, physically, spiritually, relationally, and economically during the ongoing COVID-19 crisis. Therefore, this limited their leadership to their congregations during the pandemic (Osei-Tutu et al., 2021a; Stetzer, 2021). The problem is amplified when someone does not experience social support or have higher emotional intelligence in high-stress environments (Grey et al., 2020; Malinauskas & Malinauskiene, 2020; Thomas & Barbato, 2020). Unfortunately, evangelicals may be ill-equipped for the long-term care of their churches, congregants, and leaders during the COVID-19 crisis (Aten & Boan, 2016; Corbett & Fikkert, 2012).

The problem is that evangelicals in the United States have been significantly understudied in mental health, perceived social support, emotional intelligence, and perceived stress, especially in a pandemic and with quantitative analyses. The impact of the problem is an inability to understand and strategically implement care to congregants and community care among Southern Baptists and other evangelical congregations. Applying a three-way analysis may help bridge the divide between higher levels of mental health with specific levels of perceived social support, emotional intelligence, and perceived stress. Perceived social support has been researched to improve mental health (Bareket-Bojmel et al., 2021; Chou et al., 2020; Grey et al., 2020; Grosch & Olson, 2000; Malinauskas & Malinauskiene, 2020; Saltzman et al., 2020). A gap exists in literature when an interaction is researched between perceived social support and mental health. The current research addresses this gap by studying the interaction of trait emotional intelligence and perceived stress on the relationship between perceived social support and mental health. Scant research has been completed utilizing perceived stress as a secondary moderator. It is unknown how trait emotional intelligence and other variables will be impacted by certain levels of perceived stress. A sample of Southern Baptists representing evangelicals in the United States will be studied.

Purpose Statement

The purpose of this quantitative research is to evaluate the interaction of perceived stress and emotional intelligence on the relationship between perceived social support and mental health among evangelicals in the United States during the COVID-19 pandemic. Gaps in current research include mental health analysis among evangelicals, especially Southern Baptists in the United States; studying mental health, perceived social support, emotional intelligence, and perceived stress among Southern Baptists and evangelicals; researching COVID-19 and variants

impact on evangelical mental health; the use of quantitative research with the before mentioned variables; and the application of a moderated moderation study using the secondary moderation interaction of perceived stress. The current research addresses these gaps by studying the interaction of trait emotional intelligence and perceived stress on the relationship between perceived social support and mental health among a sample of Southern Baptists, as affiliated with evangelicalism, in the United States during the COVID-19 pandemic.

Significance of the Study

This study is a unique contribution and complement to present behavioral sciences and social studies literature. While mental health has been significantly researched in the past several years (Clinton & Hawkins, 2009; Francis et al., 2017; Keyes, 2009; McGaffin et al., 2015; Sapolsky, 2004; Westerhof & Keyes, 2010), scant research has been completed on evangelicalism and Southern Baptists in the United States. Also, while mental health has been significantly researched amid COVID-19 (Coppola et al., 2021; Czeisler et al., 2020; Daly et al., 2021; Winkler et al., 2020), insufficient studies have been conducted on the interaction of perceived stress and emotional intelligence on the relationship between perceived social support and mental health. Additionally, while perceived social support, emotional intelligence, and perceived stress have been researched during COVID-19 (Grey et al., 2020; Malinauskas & Malinauskiene, 2020; Thomas & Barbato, 2020), no research was found utilizing a three-way interaction with these variables relating to mental health.

Evangelical and Southern Baptist church members can become an extension of God's peace in the world (I Corinthians 12:12-14; Erickson, 2013; Köstenberger, 2010). If church members struggle with mental health challenges, their ministry to the community can be severely limited since the congregants will need care themselves. If the congregation is hurting, their

caring ministry to the community may be limited (Aten & Boan, 2016; Clinton & Hawkins, 2009; Corbett & Fikkert, 2012; Wright, 2011). Also, little research and writing have been completed on this topic. Due to the lack of research and writing among evangelicals and Southern Baptists on mental health during the COVID-19 pandemic, the significance of the current study could include inviting conversations to this much-needed topic and inviting hope in the pain and suffering within the congregation and community (Erickson, 2013; Lambert, 2016; Wright, 2011). Consequently, this study can provide a broader application to evangelicals in the United States since the SBD is an evangelical denomination. Similar doctrine and congregational ministries could be impacted in similar ways during the COVID-19 pandemic.

Research Questions

- **RQ1:** Is perceived social support significantly related to the mental health of evangelicals during the COVID-19 pandemic?
- **RQ2:** How does the interaction of perceived social support and mental health depend on emotional intelligence?
- **RQ3:** How does the interaction of perceived social support and mental health depend on perceived stress?
- **RQ4:** What effect does emotional intelligence have on mental health?
- **RQ5:** What effect does perceived stress have on mental health?
- **RQ6:** What effects do emotional intelligence and perceived stress have on mental health?
- **RQ7:** How do the interaction of perceived social support, emotional intelligence, and mental health depend on perceived stress?

Definitions

1. *Mental health:* Mental health is the presence of emotional well-being and high levels of social functioning (McGaffin et al., 2015). To have flourishing mental health, a person would indicate positive emotional, social, and psychological wellbeing every day or almost every day from the past month (Hough et al., 2019).
2. *Evangelicalism:* Evangelicalism can be characterized by a dynamic form of Christianity in the world (Hindmarch, 2018). The centerpiece of evangelicalism is the person, work, and way of Jesus Christ as exemplified by His crucifixion and resurrection (Dever, 2013; Erickson, 2013; Rosell, 2020). Within evangelicalism, local churches practice Christianity as the body of Christ in the world (Matthew 28:18-20; Acts 1:8; I Corinthians 12:12-14). Southern Baptists are evangelicals and are sampled in this research (Cagle, 2021; SBC, n.d.a.; SBC, n.d.b.; Smietana, 2021).
3. *Perceived social support:* Perceived social support involves receiving and giving support between at least two individuals (Zimet et al., 1988). The basic premise is that a person feels supported if cared for and loved by another (Freeze, 2017). Perceived social support has seminal roots in attachment theory popularized by John Bowlby and Mary Ainsworth (Feldman, 2008; Freeze, 2017; Mikulincer & Shaver, 2007; Seligman & Reichenberg, 2014; Tan, 2011). Attachment theory is a natural and social lifespan account of how close relationships are formed, maintained, and dissolved (Mikulincer & Saver, 2007).
4. *Emotional intelligence:* Emotions can be defined as impulses to action (Goleman, 2006). Emotional intelligence is a person's ability to recognize emotions in themselves, discern emotions in others, and manage these emotions in a healthy way

(Bradberry & Greaves, 2009). Emotional intelligence includes a personal competence and social competence (Gutierrez & Mullen, 2016; Merida-Lopez & Extremera, 2017). Four essential areas of emotional intelligence include self-awareness, self-management, social awareness, and relational management (Bradberry & Greaves, 2009).

5. *Perceived stress:* Stress is a natural, expected, and normal response to life's situations, events, and demands (Sapolsky, 2004). Perceived stress is the degree to which events and conditions in a person's life are considered stressful (Cohen, 1994).

Summary

The problem is that evangelicals in the United States have been significantly understudied in mental health, perceived social support, emotional intelligence, and perceived stress, especially during a pandemic and with quantitative analyses. Gaps in current research include mental health analysis among evangelicals and Southern Baptists; studying mental health, perceived social support, emotional intelligence, and perceived stress among evangelicals; researching the COVID-19 virus and its variants' impact on evangelical mental health; the use of quantitative research with the before mentioned variables; and the application of a moderated moderation study using the secondary moderation interaction of perceived stress. The purpose of this quantitative research is to evaluate the interaction of perceived stress and emotional intelligence on the relationship between perceived social support and mental health among evangelical church members in the United States during the COVID-19 pandemic. This study is a unique contribution and complement to present behavioral sciences and social studies literature among evangelicals. This research will address multiple critical gaps. The significance of this study can include inviting conversation to this much-needed topic, encouraging hope in

the pain and suffering within the congregation and community, and providing broader application to the population of evangelicals in the United States from a sample of Southern Baptists.

CHAPTER TWO: LITERATURE REVIEW

Overview

The purpose of this quantitative research is to evaluate the interaction of perceived stress and emotional intelligence on the relationship between perceived social support and mental health among evangelicals in the United States during the COVID-19 pandemic. This chapter discusses significant research findings for this present study. This literature review aims to compile research on COVID-19 impacts, mental health, perceived social support, emotional intelligence, and perceived stress among evangelicals and a sample of Southern Baptists.

First, this chapter reviews the pertinent literature regarding the enduring impacts of COVID-19. Second, mental health is discussed in terms of definition, description, and impact. Third, a biblical application of mental health is addressed. Next, perceived social support constructs and effects are explored. Also, emotional intelligence is researched and reviewed as an integral part of this study. Finally, perceived stress is analyzed, defined, and discussed. The proposed research addresses the critical gaps and significance in research while outlining how the intended topics complement the scope of research literature.

Related Literature

COVID-19 Impact

COVID-19 is an infectious disease caused by SARS-CoV-2 (Centers for Disease Control and Prevention [CDC], n.d.). Before the outbreak in China in 2019, there was no information about this virus (CDC, n.d.). However, COVID-19 quickly became a global pandemic and a biological disaster. A biological catastrophe is one of the most significant health threats to an individual (Levers, 2012). In addition, COVID-19 could be considered a traumatic event that increased physical, emotional, and psychological harm (Ettman et al., 2020). Over 80 million

cases of COVID-19 have been reported in the United States to date, with over 900,000 deaths (WHO, n.d.). In the United States, deaths attributed to COVID-19 are over four times the number killed during the Vietnam War (Simon et al., 2020).

There were voluminous harms and dangers involved with COVID-19. Physical symptoms include fatigue, high fever, dry cough, and difficulty breathing (CDC, n.d.). Hospitalization may be necessary in extreme cases. Mental health deteriorated due to fear, stress, isolation, and loneliness (Czeisler et al., 2020; Levers, 2012; Sapolsky, 2004). COVID-19 was associated with social distancing, lockdown restrictions, and quarantine, which was expected to have marked and enduring mental health effects (Coppola et al., 2021; Czeisler et al., 2020; Daly et al., 2021). Variants of the disease are being studied around the world. For instance, the Delta variant is more transmissible with a higher rate of infections (Alexander et al., 2021).

During the COVID-19 pandemic, elevated levels of mental unhealth, substance use, and suicidal thoughts were reported in the United States (Czeisler et al., 2020). Symptoms of anxiety, depression, stress, and disturbed sleep have been associated with COVID-19 (Rajkumar, 2020; Winkler et al., 2020). Women have experienced lower mental health than men during the COVID-19 pandemic (Coppola et al., 2021).

Predictors of well-being, mental health, and emotional distress were researched during the COVID-19 pandemic (Chapman et al., 2021; Dlugosz, 2021; Margetic et al., 2021). Some of the adverse effects on mental health were derived from government restrictions designed to control the spread of the virus, including social distancing, wearing masks, and quarantine (Chapman et al., 2021; Dlugosz, 2021). Unhealthy lifestyle behaviors such as substance use, poor nutrition, lack of sleep, and inactivity also predicted lower well-being and mental health (Chapman et al., 2021). Reduced social contact, financial insecurity, employment instability, and

fear of the virus created emotional distress (Chapman et al., 2021). Fear, in general, activates a physical adaptive function in a person's brain and body to be on heightened alert and focused attention (Dlugosz, 2021; Sapolsky, 2004). Chronic states of heightened sensitivity created a foundation for lower levels of well-being and mental health with increased emotional distress (Chapman et al., 2021; Dlugosz, 2021; Margetic et al., 2021). A lack of coping and perceived social support exacerbated mental health issues (Margetic et al., 2021).

Mental health includes positive feelings, psychological well-being, and relational health (Lamers et al., 2011). Conversely, a person experiencing low mental health has a higher risk of having low emotional, psychological, and social well-being (Lamers et al., 2011). For example, a person may have worried alone during the COVID-19 pandemic (Winkler et al., 2020). Following the primary traumatization of the biological disaster, long-term stress can result in depression, anxiety, or other mental health concerns, like suicide, burnout, and grief (Clinton & Hawkins, 2009; Levers, 2012).

Post-COVID-19 research could account for increased mental illness, especially with people who have fewer resources and negative coping behaviors (Ettman et al., 2020). The first wave of the COVID-19 crisis included physical and economic struggles. The second wave of the pandemic consists of rising mental health and substance use disorders (Simon et al., 2020). Since the magnitude of sickness and death was a historic-scale tragedy, mental health could have a propensity to decrease (Simon et al., 2020). Unfortunately, there may not be adequate mental health services available, even among churches and denominations, like the Southern Baptist Convention (Trygg et al., 2019).

Variants of the virus are expected to occur (CDC, n.d.). For instance, the Delta variant, a highly contagious virus strain, was first identified in December 2020 (CDC, n.d.). The Omicron

variant was identified in November 2021. Vaccines are strongly encouraged, along with wearing masks in public indoor venues. However, significant discrepancies in decision-making and following guidelines continue across the Unites States (CDC, n.d.). The difference has created confusion in communities, schools, and places of worship. Some groups follow the guidelines while others do not. Some local congregations have resumed online services, some have returned to campus, and others have returned to campus and closed again (Bryson et al., 2020; Pillay, 2020). Research has not been completed on the impacts of the multiple variants on mental health.

COVID-19 and the Evangelical Local Church

Not only were people fearful of the virus, but the pandemic also created economic and social problems that impacted homes, churches, schools, businesses, and communities (Coppola et al., 2021). One of the direct losses of the Christian community was the ability to meet on campus and worship God corporately (Bryson et al., 2020). Worship services were transported digitally into people's homes (Bryson et al., 2020). More importance was given to space rather than a place for worship services (Bryson et al., 2020). Consequently, the secular and sacred blended problems amid isolation and lack of togetherness (Bryson et al., 2020). Poor work-related mental health concerned church leaders across denominations and cultures (Francis et al., 2017).

Another challenging impact was against the community and congregational ministry of the local church (Bryson et al., 2020; Coppola et al., 2021). Pastors in the United States and beyond were being as creative as possible to continue to share the love of God and encourage people amid fear, anxiety, stress, and hopelessness (Afolaranmi, 2020). Pastoral care and ministry transitioned from in-person on a church campus to online platforms like social media, websites, streaming services, and teleconferencing (Afolaranmi, 2020; Bryson et al., 2020).

Little has been written about the ministry of the congregants of the local church. This could have been difficult to measure due to lockdown and social distancing orders during the pandemic (Afolaranmi, 2020; Coppola et al., 2021; Czeisler et al., 2020; Daly et al., 2021).

COVID-19 has impacted and disrupted everyday life experiences, including the church. Local churches have been compelled to adapt like restaurants, schools, sporting venues, public transportation, and doctors' offices (Pillay, 2020). There has been a worship shift and a missional shift in how the church and community receive care. There has been a theological shift as well. Local churches are answering what it means to be the church versus going to church (Pillay, 2020). Local congregations may be in an uncomfortable conundrum while facing worship, missional, and theological shifts (Pillay, 2020).

Characteristics of Evangelicalism

Evangelicalism can be characterized by a dynamic form of Christianity in the world (Hindmarch, 2018). The centerpiece of evangelicalism is the person, work, and way of Jesus Christ as exemplified by His crucifixion and resurrection (Dever, 2013; Erickson, 2013; Rosell, 2020). Within evangelicalism, local churches practice Christianity as the body of Christ in the world (Matthew 28:18-20; Acts 1:8; I Corinthians 12:12-14). Evangelicalism encompasses the local church and directly impacts people and individual members of a congregation (Erickson, 2013).

Still, local evangelical churches have different characteristics based on research and scholarship. For instance, Dever (2013) describes healthy evangelical local churches using nine marks. The marks of a healthy evangelical local church include expositional preaching, biblical theology, gospel centricity, conversion, evangelism, church membership, church discipline, discipleship, and church leadership. Rosell (2020) includes only five characteristics in his

definition. The characteristics include the centrality of the cross of Christ, shared biblical authority, conversion, worldwide evangelization, and spiritual renewal of the church and society. Regardless, evangelicalism is grounded in the person and work of Jesus Christ.

Southern Baptists are a part of the evangelical movement. Southern Baptist's most recent statement of faith is the Baptist Faith and Message from 2000. The Baptist Faith and Message (2000) is evangelical by design and contains 18 sections. The sections include descriptions about the Bible, God, man, salvation, the church, ordinances, and the family (Baptist Faith & Message, 2000). Other sections are included and remain distinctly evangelical. For example, at the center of each area is the person and work of Jesus Christ.

Spiritual Well-Being During COVID-19

Evangelicals reported lower levels of perceived spiritual well-being during COVID-19 than before the pandemic (Coppola et al., 2021). Spirituality and religious practices, like church attendance, seem to be protective factors connected to mental health and spiritual well-being (Coppola et al., 2021). Prayer was also influential in decreasing stress symptoms and associated trauma (Szalachowski & Tuszynska-Bogucka, 2021). Spiritual suffering during COVID-19 was compounded by isolation, loneliness, quarantine, financial insecurity, and vulnerability (Ferrell et al., 2020). Spiritual injury and distress are exacerbated to caregivers during the COVID-19 pandemic due to the burden of serious illness, secondary traumatic stress, grief, and compassion fatigue (Ferrell et al., 2020). In addition, caregivers' and church leaders' spiritual needs must be addressed due to the costs of giving care during a pandemic (Ferrell et al., 2020). Left unaddressed, the personal cost of caring for others could lead to burnout and secondary trauma (Levers, 2012).

Evangelical Church Leadership During COVID-19

Church leaders were challenged mentally, emotionally, physically, spiritually, relationally, and economically during the ongoing COVID-19 crisis. Leadership best practices during the COVID-19 pandemic include servant leadership, shared leadership, flexibility, and clear communication (Fernandez & Shaw, 2020). In Ghana, during the lockdown due to COVID-19, religious leaders experienced a loss of spiritual disciplines, a loss of fellowship, disruption of normalcy, anxiety, and financial concerns. However, church leaders had more time with their families, increased their faith in God, and had more time for self-care (Osei-Tutu et al., 2021a).

Three out of four pastors know of someone with mental illness, and over half of the church leaders know of at least three people that are depressed (Stetzer, 2021). Almost one out of every four church leaders stated that they battled mental illness (Stetzer, 2021). Nearly half of the church leaders mentioned that they rarely speak about mental illness, but they believed the church could be a resource (Stetzer, 2021). Three out of four families interviewed wanted to see more information on mental health from the church (Stetzer, 2021).

Churches continue to play an essential role in providing spiritual and emotional care in the wake of disasters (Entwistle et al., 2018). Suffering is foundational to the fall of humankind (Entwistle, 2018; Genesis 3:17-19). Church services were offered to lament suffering and worship God amid difficulty. Communal lamenting may invite a cure and orients a person to the comprehension and experience of a present and available God (Ng, 2018).

Resiliency in church leadership was needed to achieve long tenure and ministry efficacy during the pandemic (Strunk et al., 2017). In addition, if pastors had a conviction of their calling into pastoral ministry to a given congregation, they were more resilient to the stress of biological disaster (Strunk et al., 2017). Therefore, pastors are encouraged to have a ministry philosophy

that includes social support and resiliency in ministry during the COVID-19 pandemic and other crises that may befall them (Strunk et al., 2017).

Evangelical Congregational Mental Health During COVID-19

There is a connection between religious faith, higher mental health, and greater well-being (Koenig, 2021; Park et al., 2019). Religious belief is also associated with lower alcohol and drug use, decreased rates of depression, and lessened suicidal ideation (Koenig, 2021). In Ghana, during the COVID-19 pandemic, church congregants experienced a decline in spiritual life, loss of fellowship, financial difficulties, childcare challenges, and fear of the infection (Osei-Tutu et al., 2021b). Church leaders intervened by sharing messages of hope, healing, and repentance (Osei-Tutu et al., 2021b).

One of any religion's mental health functions is to buffer against anxiety (Van Tongeren et al., 2016). Extrinsic religious people view religion as instrumental for comfort, belonging, and purpose. The extrinsically religious harnessed faith to lower anxiety in times of crisis (Van Tongeren et al., 2016). The intrinsic religious internalize motivations and guiding behavior and are more resilient during a crisis, especially when extrinsic religious coping is removed during a global pandemic (Van Tongeren et al., 2016).

In a study, highly religious people scored higher in anxiety and lower in worry. The high anxiety led to irrational behavior among the highly religious, leading to hoarding toilet paper, avoiding vaccination, and desiring to attend corporate worship services without distancing during a pandemic (Kranz et al., 2020). Religion can be a positive coping behavior and a source of resilience. Alternatively, religion can become a risk factor connected to negative associations with analytical thinking due to higher rates of anxiety (Kranz et al., 2020). Religious people tend

to overreact emotionally and engage in unreasonable and irrational behavior during a crisis (Kranz et al., 2020).

Alternatively, religious coping decreased depression, anxiety, and stress (Chow et al., 2021; DeRossett et al., 2021; Szalachowski & Tuszynska-Bogucka, 2021). Positive religious coping was associated with lessened depression and anxiety. Negative religious coping was associated with higher rates of depression and anxiety (Chow et al., 2021; DeRossett et al., 2021). Mixed results for stress were analyzed in one research study on religious coping. The role of prayer was studied to decrease stress and traumatic outcomes, whereas other religious coping skills increased stress (Szalachowski & Tuszynska-Bogucka, 2021).

Southern Baptists in the United States During COVID-19

There are over 435,000 local congregations and 14 million members in the Southern Baptist Denomination (SBD) (Smietana, 2021). Unfortunately, the church, congregants, and financial numbers continue to decline (Smietana, 2021). This declining trend is analogous among Southern Baptists on a global scale (Cagle, 2021). In June of 2021, the Southern Baptist Convention (SBC) held its annual meeting in Nashville, TN. The SBC canceled the yearly meeting in 2020 due to the COVID-19 pandemic (TAB Media, 2020). A “Vision 2025” plan was constructed to overcome the convention’s persistent decline (Cagle, 2021; SBC, n.d.b).

The SBC envisioned adding missionaries on the field, increasing the number of local churches in the United States, calling out men and women to full-time vocational ministry, increasing cooperative giving to the SBC, and ceasing the decline of baptisms (Cagle, 2021). In addition, eliminating all sexual abuse and racism was also considered part of the vision (Cagle, 2021).

The SBC must be distinguished from the denomination of Southern Baptists. The convention is a part of the denomination that contains 12 entities and one auxiliary (Iorg, 2021). Entities include the Executive Committee that encourages cooperation and support, The Ethics and Religious Liberty Commission, Guidestone Financial Resources, The International Mission Board, Lifeway Christian Resources, The North American Mission Board, and six theological seminaries in the United States (SBC, n.d.a). Alternatively, the denomination has one national convention, 42 state conventions, over 48,000 churches, and numerous other ministries that include hospitals, camps, and children's homes (Iorg, 2021). The SBC has no authority over the SBD since SBD groups and churches are autonomous and pursue cooperation through the cooperative efforts of the SBC (Iorg, 2021).

Division continues in the SBD among autonomous local churches amid COVID-19 issues (Cagle, 2021). A call for unity during the convention was resolved. Other resolutions involved maintaining a public witness for Jesus Christ, emphasizing the sufficiency of Scripture for racial reconciliation, protecting women in the church and ministry, and grieving the lives of those who died during the COVID-19 pandemic (Cagle, 2021). Before the SBC annual meeting, questions concerning SBC unity abounded due to the differences among local churches, political agendas, racial discrimination, gender inequality, and theological variance (TAB Media, 2021).

Despite these challenges, little has been written about the SBC, SBD, and mental health, even in cyclical state publications from Alabama, Georgia, Tennessee, Louisiana, Florida, and Mississippi. For instance, most Southern Baptist state associations and groups publish weekly papers. Yet, fewer than ten items have been discovered in the Alabama, Georgia, Tennessee, Louisiana, Florida, and Mississippi periodicals regarding mental health since the pandemic

began in March 2020. This is surprising because mental health was significantly impacted during the COVID-19 pandemic (Coppola et al., 2021; Czeisler et al., 2020; Daly et al., 2021).

Interestingly, the most popular search for a Bible verse in 2020 was Isaiah 41:10. Isaiah 41:10 reads, “So do not fear, for I am with you; do not be dismayed, for I am your God. I will strengthen you and help you; I will uphold you with my righteous right hand” (NIV). This Bible verse accounted for 80% of searches in a popular Bible app (The Alabama Baptist, 2020). The most popularly searched word when the pandemic began was fear. As the pandemic continued, the most searched words became peace, hope, and faith (The Alabama Baptist, 2020).

Southern Baptist dissertations were researched from the past ten years as the study's sample. Scant studies were located on this topic with this denomination. Other denominations like Methodist, Anglican, Pentecostal, Open Bible, Presbyterian, and Assemblies of God were modestly represented rather than Southern Baptists (Brewer, 2016; Francis et al., 2013; Francis et al., 2017; Proeschold-Bell et al., 2013). Mental health studies among denominations typically involved burnout, self-care, and general psychological wellbeing among church leadership in mixed-method or qualitative designs (Brewer, 2016; Cochran, 2018; Hessel, 2015; Hester, 2018; Joubert, 2020; Lancaster, 2020; Lewis, 2017; McClanahan, 2018; Miller-Clarkson, 2013; Stephens, 2020; Williams, 2009). More quantitative research is needed in mental health among evangelicals, and Southern Baptists since mental health is an issue during the COVID-19 pandemic.

Southern Baptist Congregational Community Care During COVID-19

The restriction of religious gatherings also impacted congregational care and ministry to the surrounding communities (Osei-Tutu et al., 2021a; Osei-Tutu et al., 2021b). Southern Baptist local churches were affected as well. More than two-thirds of the 435,000 Southern Baptist

churches are located in rural areas (Cagle, 2021; Smietana, 2021). As numbers continue to decline, COVID-19 heightened the issues of financial and human resources in an already stressed situation (Cagle, 2021; Francis et al., 2020). The “Vision 2025” plan designed by the SBC did not directly address the issues associated with COVID-19, especially in the area of mental health (Cagle, 2021; SBC, n.d.b).

COVID-19 is a biological catastrophe that continues to create crises in the way of mental health, financial insecurity, and physical illness (Coppola et al., 2021; Czeisler et al., 2020; Daly et al., 2021; Ettman et al., 2020; Levers, 2012; Simon et al., 2020). Even though Southern Baptists have the third largest disaster relief organization globally, the local church is ill-equipped to meet the demands of the COVID-19 crisis in the long term due to the mental health nature of the issue (Alabama Baptist Disaster Relief, n.d.). A crisis typically involves a temporary loss of coping skills; however, the emotional distress could be reversible (Wright, 2011). Since little research and analysis has been completed in the SBC and SBD, addressing mental health issues continues to be a problem. Regardless, the COVID-19 disaster and mental health issues can be better handled through awareness and training among Southern Baptists. This research could propel healthy conversations and appropriate determined action in these areas.

There are several phases of a disaster. The stages include the impact, heroic, honeymoon, disillusionment, and reconstruction phases (Aten & Boan, 2016). The impact phase is when the disaster interrupts a usual way of life. A warning or caution preceded the impact phase of COVID-19 in 2020 (Aten & Boan, 2016). The heroic phase is associated with altruism, quick action, and a focus on the well-being of loved ones. In the week to months following a disaster, the honeymoon phase is associated with readily available civic and governmental help (Aten &

Boan, 2016). Overall, there is a sense of calm and hope in this phase. Once the available support ends, the disillusionment phase begins. Since COVID-19 is a global pandemic, the honeymoon phase was short-lived (World Health Organization, n.d.). Disillusionment is a time of transition between primary recovery and long-term restoration. In the reconstruction phase, people impacted by the crisis begin taking personal responsibility to be a part of the solution to deal with the problems of the disaster (Aten & Boan, 2016). Impacted individuals who assume personal responsibility are more prepared to help others as well.

The reconstruction phase can extend years beyond the disaster as people learn new coping behaviors to strengthen their resilience (Aten & Boan, 2016). Crisis and disaster response are appropriate for immediate relief when people have lost the ability to cope. However, local churches often provide little help for ongoing rehabilitation and development to prepare for the next crisis (Corbett & Fikkert, 2012). Restoration involves helping the person who have become personally responsible for their well-being and is journeying toward a new norm (Corbett & Fikkert, 2012). Development concerns equipping a person to be better prepared and more resilient for future crises and disasters (Corbett & Fikkert, 2012; Wicks, 2010). Training, awareness, and education can support local church efforts to provide more than crisis care in a sustainable system that transcends the apparent needs created by a disaster like COVID-19.

Mental Health During COVID-19

Mental health is the presence of emotional well-being and high levels of social functioning (McGaffin et al., 2015). In the United States, one out of every five people have a mental disorder in a given year, and at least 450 million people have a mental health issue worldwide (Stanford, 2021). Every year, one in five adults in the United States experiences mental illness (Shaw et al., 2021). Moreover, mental unhealth may continue to be one of the

primary issues during and following the COVID-19 pandemic (Coppola et al., 2021; Czeisler et al., 2020; Daly et al., 2021; Winkler et al., 2020).

Mental illness was an issue among other pandemics as well. Mental health issues were raised among smallpox, plagues, Ebola, influenza, and HIV outbreaks (Janssen, 2021). Like COVID-19, these pandemics benefitted from a Christian response to improve mental health (Janssen, 2021). Messages of hope contained specific perspectives during the pandemics of the past. Overall, churches encouraged people through compassion and teaching about how God creates, redeems, heals, and restores (Southgate, 2021). Healthier mental resilience during pandemics, and COVID-19, was derived from robust social support and intrapersonal stability (Vicini, 2021). Unfortunately, many people with mental illness during COVID-19 were isolated and self-preserved rather than having the ability to help others (Vicini, 2021). If a person needed mental health assistance during COVID-19, many sought clergy for help due to affordability and availability (Stanford, 2021; Yarbrough, 2019).

Evangelical Church Leaders and Mental Health

There is limited research on mental health and well-being of church leaders. This creates little understanding of contextual and cultural awareness on clergy issues (Shaw et al., 2021). A primary concern is that pastors are tired and struggling with mental health issues themselves (Stanford, 2021). The rate of distress and depression among clergy is rising (Shaw et al., 2021). In fact, the rates of despair and depression among church leaders are higher than the national average (Shaw et al., 2021). Pastors became an easy target for hurting people while dealing with their high stress due to decision-making and caring for the sick while social distancing (Wilkey, 2021).

Loss of satisfaction in ministry and emotional exhaustion could be factors for low mental health and burnout among church leaders during the COVID-19 pandemic (Beavis, 2019; Doolittle, 2010; Francis et al., 2017; Jacobson et al., 2013; Visker et al., 2017). Mental health could be impacted by anxiety, depression, and suicidal thoughts (Francis et al., 2017). Church leaders are susceptible to burnout due to providing care's intimate and emotional nature (Gutierrez & Mullen, 2016). Religion and spirituality may buffer against compassion fatigue and burnout if the church leader remains resilient (Newmeyer et al., 2016).

Church leaders flourishing in mental health are characterized by more others-focus and less selfish motivations (Wissing et al., 2021). Alternatively, leaders with languishing mental health have more of a self-focus and selfish reasons to pursue their satisfaction (Wissing et al., 2021). Criticism, loneliness, and stress are higher among the clergy (Grosch & Olson, 2000; Lifeway Research, 2016; Proeschold-Bell et al., 2013). There is a growing concern for church leaders' mental health as they give care (Adams & Bloom, 2017). It is reasonable to conclude that church leaders' mental health and well-being will continue to decline during the COVID-19 pandemic (Shaw et al., 2021).

The church leaders' mental health directly impacts the congregation (Epperly, 2014). If a church leader struggles mentally, the assembly may also struggle (Issler, 2012). Furthermore, mental health may decline in a congregation if not led toward healing by the church leader (Koenig, 2021; Van Tongeren et al., 2016). Therefore, assessing the congregation's mental health could reveal an issue with the leadership (Epperly, 2014; Ketheredge & Erwin, 2017).

Anxiety, Depression, and Stress

Anxiety, depression, and stress have risen during the COVID-19 pandemic. Anxiety disorder symptoms were three times higher during COVID-19 than reported before the pandemic

(Czeisler et al., 2020). Depressive disorders increased approximately four times higher during the pandemic than previously reported (Czeisler et al., 2020; Daly et al., 2021; Ettman et al., 2020). Young adults were more vulnerable to depressive symptoms during the COVID-19 pandemic (Daly et al., 2021). In addition, disruptions to physical activity, sleep, rest time, and issues with previous mental health concerns were shown to increase depressive symptoms (Giuntella et al., 2020). Steps per day were halved during the pandemic, sleep increased by 30 minutes, socializing with friends decreased, and screen time doubled to over five hours per day (Giuntella et al., 2020).

Depression symptoms included feeling sad and hopeless while losing interest and pleasure in doing things that once were considered enjoyable (Daly et al., 2021). People who lost their jobs or reported fewer resources indicated a greater affinity for depressive symptoms (Ettman et al., 2020). Young adult depression symptoms and diagnosis may not improve with restoring pre-pandemic activity levels (Giuntella et al., 2020).

The stress caused by the COVID-19 pandemic is likely to profoundly affect mental health (Kujawa et al., 2020). Adults are at high risk for depression and anxiety caused by pandemic stress (Kujawa et al., 2020). Stress is a normal response to life events (Sapolsky, 2004). Acute stress can be beneficial and even save a person's life (Selye, 2013). The most problematic issues occur amid chronic stress that can be seen during the COVID-19 pandemic (Kujawa et al., 2020; Sapolsky, 2004). Stressors included interpersonal relationships, occupational volatility, and financial strain (Kujawa et al., 2020). Consequently, high levels of stress are associated with leader burnout (Harms et al., 2017). Also, high stress levels are related to burnout in subordinates and congregants (Harms et al., 2017).

Suicide

Suicide rates continue to rise during the COVID-19 pandemic (Gunnell et al., 2020; Page, 2021). There is a severe spike in suicide among young adults between the ages of 25-39. In addition, suicide is increasingly higher among middle-aged and senior adults (Page, 2021). There are 91 suicides per day or one suicide every 15 minutes (Page, 2021). The increase in substance use during the pandemic was due to negative coping behaviors due to stress and unwanted emotions (Czeisler et al., 2020). Vulnerable groups with fewer resources and people struggling with mental illnesses like depressive symptoms are at greater risk for suicidal tendencies (Gunnell et al., 2020).

Suicide risks are exacerbated by financial stressors, physical illness, isolation, domestic violence, alcohol consumption, loneliness, bereavement, and irresponsible media reporting of increased suicide rates (Gunnell et al., 2020). In addition, the threats of suicide increased due to longitudinal mental and physical health decline, loss of support systems, increased isolation, multidimensional fears, grief, availability of alcohol and opioids, and access to weapons (Moutier, 2020). More research will be needed to assess if suicide rates increase post-pandemic (Gunnell et al., 2020; Moutier, 2020). Unfortunately, the suicide and suicide ideation rates seem to increase (Gunnell et al., 2020).

Grief

Grief is a response to loss (Wright, 2004). The loss can be experienced in the workforce, community, church, or home. During COVID-19, loss was prevalent and exacerbated by the presence of declining mental health that can include a mixture of strong emotions, including sadness, anger, guilt, shame, or shock (Simon et al., 2019). The transformation of normal grief from pre-pandemic losses is amplified due to prolonged distress and depressive symptoms

lasting more than six months (Simon et al., 2020). During the COVID-19 pandemic, people with prolonged grief has difficulty accepting the loss and reengaging in everyday activities (Eisma, 2020; Kealy, 2017).

Grief can become a pathway to hope and healing (Clinton & Hawkins, 2009; Wright, 2004; Wright, 2011; Zhai & Du, 2020). Normalizing grief can significantly benefit the person who has experienced loss (Clinton & Hawkins, 2009; Wright, 2011; Zhai & Du, 2020). Regardless, the grief journey is hard work (Wright, 2011). If a person chooses not to seek help during grief, the journey toward healing and mental health can be arduous and improbable (Clinton & Hawkins, 2009; Wright, 2011). The grief and loss experienced during COVID-19 impacted the religious and non-religious; therefore, people are prone to experience decreased mental health (Coppola et al., 2021; Czeisler et al., 2020; Eisma, 2020; Zhai & Du, 2020).

Well-Being During COVID-19

Psychological, physical, and relational well-being were limited during the COVID-19 pandemic. Well-being consists of happiness and flourishing mental health (Adams & Bloom, 2017). Happiness is the quality of people experience in their daily lives, and flourishing is the meaning and purpose individuals experience in their lives (Adams & Bloom, 2017). Flourishing includes the meaning and purpose in life, positive relational connectedness, authenticity, self-awareness, and higher personal standards (Adams & Bloom, 2017). Caregivers, like church leaders, can suffer from irritability, aggravation, loss of empathy, compassion fatigue, and burnout with lower well-being (Mathieu, 2007). In addition, increased clergy depression and anxiety rates can decrease well-being while increasing job stress and ministry dissatisfaction (Proeschold-Bell et al., 2013).

Biblical Application for Non-Diagnostic Mental Health

God created humankind in His image (Genesis 1:26-27). During creation, God created the world with boundaries to fill His design with good, including humanity (Genesis 1). Thus, a person is created as an emotional, mental, spiritual, physical, and relational being in the image of God (Erickson, 2013; Rice, 2017). Additionally, humanity was created as a loved, accepted, and beautiful masterpiece of God's magnificent design (Nichols, 2017). Therefore, people are holistic and distinct in creation and design (Psalm 139:13-14). God desires His creation to flourish in all areas of life, including mentally (Erickson, 2013; Grant, 2021; Lambert, 2016; Lamers et al., 2010; Westerhof & Keyes, 2010; Wissing et al., 2019).

Unfortunately, people have sinned and marred the image that God created (Romans 3:23). The suffering, pain, trauma, brokenness, and hurt were not part of God's original design and plan (John 15:18-19; Romans 6:23; I Peter 5:8). The Deceiver's, Satan's, primary objective is to destroy the image that God created (John 10:10). Inevitably, the result of sin shatters the spiritual, mental, emotional, physical, and relational image that God created (Erickson, 2013; Lambert, 2016). Consequently, among other destructive facets of a person, mental health is impacted through the destructive forces of sin (Lambert, 2016). Sin destroyed the image that God created, affecting mental health and, ultimately, God's mandate and purpose of love, unity, and multiplication (Erickson, 2013; Genesis 1:28).

God created a salvific solution through the redemption, restoration, and sacrifice of Jesus Christ (Isaiah 53:6; John 3:16). People are invited to become more like Jesus Christ in the way He created them to be, in His image (2 Corinthians 5:21; Galatians 3:13). Loss and suffering are universal (Ecclesiastes 1:15). All people endure suffering at some point and time (Ecclesiastes 3:1-3). Suffering impacts a person emotionally, mentally, physically, spiritually, and relationally

(Erickson, 2013; Lambert, 2016; Scazzero, 2015). Suffering is not wasted in God's plan, even when the strategy does not make sense (Genesis 45:5; Ecclesiastes 3:11; I Samuel 23). Suffering can become a ministry in a person's life to accomplish God's redemption in the fallen world (I Corinthians 12:7). Suffering can increase a person's ability to connect with others suffering (2 Corinthians 1).

A person following Jesus Christ can have the mind of Christ through the power of the Holy Spirit (I Corinthians 2:16). Amid a mental health crisis and suffering from the COVID-19 pandemic, few people live the abundant life promises (John 10:10). People can be restored and renewed in Jesus, who provides perfect peace. John 16:33 reads, "I have told you these things, so that in Me you may have peace. In this world you will have trouble. But take heart! I have overcome the world" (NIV). People who are following Jesus are invited to have the mind of Christ during the painful effects of COVID-19 (I Corinthians 2:16; Philippians 4:8).

Even though God intends for His people to flourish in mental health, people must join God in His redemptive work (James 2:26). The Bible does not explicitly refer to diagnostic mental health; however, there are biblical examples of non-diagnostic mental health. For instance, Elijah was a prophet of God in the Old Testament that struggled with depression and suicidal ideation (I Kings 19:4). God gave Elijah encouragement and sustenance (I Kings 19:5-8). Elijah did his part by eating, drinking, and resting to improve his mental health to continue the mission for which God had desired.

As the person becomes more like Jesus, the body of Christ can align with His mission (Matthew 28:18-20; Mark 12:30-31). A local church is a community of followers of Jesus Christ walking together and following the mission of Jesus Christ to make more and better followers of Jesus (Acts 1:8, 2:42-47). The local church, the body of believers, can become an extension of

God's peace in the world (I Corinthians 12:12-14; Erickson, 2013; Köstenberger, 2010). The church can be the flourishing instrument of peace for a culture struggling with mental health issues (Grant, 2021; Janssen, 2021; Lambert, 2016; Lamers et al., 2010; Westerhof & Keyes, 2010; Wissing et al., 2019).

Perceived Social Support

Perceived social support involves support given and received between at least two individuals (Zimet et al., 1988). The basic premise is that a person feels supported if cared for and loved by another (Freeze, 2017). Perceived social support has seminal roots in attachment theory popularized by John Bowlby and Mary Ainsworth (Feldman, 2008; Freeze, 2017; Mikulincer & Shaver, 2007; Seligman & Reichenberg, 2014; Tan, 2011). Attachment theory is a natural and social lifespan account of how close relationships are formed, maintained, and dissolved (Mikulincer & Saver, 2007). Relational attachments can influence a person positively or negatively (Mikulincer & Saver, 2007).

Adult attachment can be analyzed through anxiety and avoidance dimensions (Freeze, 2017; Njus & Okerstrom, 2016). Avoidance reveals a desire for independence, while anxiety showcases the need for care from a person’s attachment figures (Mikulincer & Saver, 2007). Lower anxiety and avoidance often reveal healthier attachment (Freeze, 2017). High avoidance and lower anxiety individuals view themselves favorably and others negatively. High avoidant and high anxiety people view themselves and others negatively. Finally, individuals with low avoidance and high anxiety have an unhealthy view of self and increase well-being by looking for support (Freeze, 2017).

Even though social support and attachment theory are connected, the two ideas are distinct (Feeney & Collins, 2015; Freeze, 2017). For instance, individual differences that may be

described by attachment theory can be associated with social support seeking, avoiding, and receiving behaviors (Freeze, 2017). High avoidance would indicate a decline in seeking support from others and failing to reciprocate care. High anxiety would suggest that a person is seeking help but not receiving expected compassionate care (Feeney & Collins, 2015; Freeze, 2017). High avoidance or high anxiety can lower perceived support (Feeney & Collins, 2015; Freeze, 2017).

Perceived social support includes support from a significant other, friends, and extended family support (Malinauskas & Malinauskiene, 2020; Zimet et al., 1988). A significant other, friend, or family member can provide social support through helping, serving, listening, caring, and supporting a person in need (Coppola et al., 2021; Grey et al., 2020; Malinauskas & Malinauskiene, 2020). However, more significant support seems to come from those closest to the person, like a significant other, close friend, or close family member (Coppola et al., 2021; Grey et al., 2020; Malinauskas & Malinauskiene, 2020).

Social support can benefit personal coping and altruistic care for others (Zimet et al., 1988). Social support has been shown to increase well-being and decrease issues in mental health like depression, anxiety, and stress (Freeze, 2017; Lutz & Eagle, 2019; Malinauskas & Malinauskiene, 2020). In addition, social support can help buffer the negative impact of complex life events by providing safety and security (Feeney & Collins, 2015; Freeze, 2017). Interestingly, perceived social support can be a better indicator of increased mental health than an objective reality of social support (Zimet et al., 1988).

People can have an average capacity of 150 personal relationships due to social, cognitive, and time limitations (Pickett et al., 2017). Exceeding the personal relationship limit for the individual can create burnout and low ministry effectiveness for the church leader (Pickett et

al., 2017). The more intimate relationships one has, the less personal relationships one can maintain; however, closer relationships are connected to greater ministry effectiveness (Pickett et al., 2017). The nuclear family seems to be a protective factor related to mental health (Coppola et al., 2021). Those who did not live alone during the pandemic or people who cared for small children reported higher perceived mental health (Coppola et al., 2021).

Individuals who experienced self-isolation during COVID-19 had statistically significant higher rates of depression and irritability compared to those who had higher perceived support (Grey et al., 2020). However, higher perceived support levels significantly lowered depression symptoms (Grey et al., 2020). Additionally, higher perceived support levels significantly increased sleep quality (Grey et al., 2020).

Emotional Intelligence

Emotions can be defined as impulses to action (Goleman, 2006). The Latin root word for emotions implies movement (Goleman, 2006). Physical movement and involvement can be derived from fear, anger, happiness, surprise, and sadness (Goleman, 2006). Emotional intelligence is a person's ability to recognize emotions in themselves, discern emotions in others, and healthily manage these emotions (Bradberry & Greaves, 2009; Rice, 2014). Emotional intelligence includes a personal competence and social competence (Gutierrez & Mullen, 2016; Merida-Lopez & Extremera, 2017).

Four essential areas of emotional intelligence include self-awareness, self-management, social awareness, and relational management (Bradberry & Greaves, 2009). Scientific literature utilizes ability or trait emotional intelligence (Malinauskas & Malinauskiene, 2020). Trait emotional intelligence will be analyzed in this study due to the straightforward way of being researched with various instruments (Malinauskas & Malinauskiene, 2020). Trait emotional

intelligence is akin to a personality construct in that a person either has emotional intelligence or does not have emotional intelligence (Merida-Lopez & Extremera, 2017). Trait emotional intelligence is concerned with an individual's ability to understand and use emotional information (Malinauskas & Malinauskiene, 2020).

Trait emotional intelligence can be identified with adaptability, assertiveness, emotional perception, impulsiveness, emotional management, self-esteem, social awareness, stress management, and optimism (Gutierrez & Mullen, 2016; O'Connor et al., 2017; Petrides, 2009; Siegling et al., 2015; Zysberg & Zisberg, 2020). Adaptability refers to a flexible approach to life. Assertive individuals are forthright. Emotional perception is the ability to be aware of one's own and others' emotions. Impulsiveness refers to the ability to think before one acts. A person can manage other people's emotions through emotional management. Self-esteem is the overall perception, analysis, and evaluation of oneself. The ability to use social skills appropriately is a valuable outcome of social awareness. A person with higher emotional intelligence can better cope with stress. Finally, optimism is linked to the well-being of an individual (Gutierrez & Mullen, 2016; O'Connor et al., 2017; Petrides, 2009; Siegling et al., 2015; Zysberg & Zisberg, 2020).

Lower emotional intelligence can be identified in many issues, including withdrawal, social problems, anxiety, depression, attention deficits, memory issues, or aggressive tendencies (Goleman, 2006). In addition, research has indicated a correlation between emotional intelligence and mental health (Malinauskas & Malinauskiene, 2020). For example, people with higher emotional intelligence tend to have more significant indications of mental health (Goleman, 2006; Malinauskas & Malinauskiene, 2020; Scazzero, 2015). Alternatively, lower emotional intelligence can decrease mental health (Goleman, 2006). Also, mental health can be

maintained with lower stress levels and higher perceived support when one has higher emotional intelligence (Malinauskas & Malinauskiene, 2020).

Emotional Intelligence and Leadership

Leaders with higher emotional intelligence can place the interests of others above their own (Fernandez & Shaw, 2020). Due to their emotional work, leaders should consider delegating and empowering others for better decision-making during the COVID-19 pandemic (Fernandez & Shaw, 2020). A more comprehensive social network may protect church leadership from the negative impact of emotional labor (Kinman et al., 2011). Emotional labor contains the frequency, intensity, and variety of emotions as part of a job responsibility (Kinman et al., 2011). Leaders should consider communicating clearly and often through various communication channels (Fernandez & Shaw, 2020). People with greater flexibility that can evolve in a crisis are best suited for leadership in a pandemic (Fernandez & Shaw, 2020).

There is a negative relationship between stress and emotional health among church leaders (Wells, 2013). Church leaders with children and higher levels of education had lower emotional health as stress increased (Wells, 2013). African-American church leaders consistently had higher levels of emotional health than Caucasian church leaders (Wells, 2013). Age and a longer tenure in ministry were related to higher levels of emotional health (Wells, 2013). Higher emotional intelligence seems to ameliorate stress levels (Malinauskas & Malinauskiene, 2020).

Perceived Stress

Stress is a natural, expected, and normal response to life's situations, events, and demands (Sapolsky, 2004). Stress refers to the physical and psychological arousal when a person perceives a change in their lives, relationships, expectations, or predictions (Harms et al., 2017). Stress can be a non-specific acute or chronic psychological, physical, emotional response

(Sapolsky, 2004; Selye, 2013). During stress, a person's brain initiates a physiological response that includes pupil dilation, accelerated heart rate, inhibited digestion, and increased mental focus (Sapolsky, 2004). Acute or immediate stress can be helpful and can save a person's life during dangerous conditions (Harms et al., 2017; Sapolsky, 2004; Selye, 2013). Alternatively, chronic stress can become more damaging than the stressor itself, causing heart disease, mental fatigue, weight fluctuations, sugar issues, lower physical energy, irritability, and inflammation (Sapolsky, 2004).

Perceived stress is the degree to which events and situations in a person's life are considered stressful (Cohen, 1994). Perceived stress has increased in the United States since the beginning of the COVID-19 pandemic (Czeisler et al., 2020; Horesh & Brown, 2020; Szkody et al., 2020). Higher levels of perceived stress during COVID-19 have been attributed to fear of the virus, social isolation, lack of emotional coping behaviors, grief, financial concerns, depression, and anxiety (Czeisler et al., 2020; Horesh & Brown, 2020; Malinauskas & Malinauskiene, 2020; Szkody et al., 2020). In addition, perceived stress can negatively affect perceived social support and emotional intelligence (Malinauskas & Malinauskiene, 2020). Alternatively, well-being, life satisfaction, and happiness are associated with levels of lessened perceived stress (Malinauskas & Malinauskiene, 2020). In line with studying Southern Baptists, religious coping has been associated with lower perceived stress when dealing with complex outcomes during COVID-19 (Thomas & Barbato, 2020).

Higher levels of perceived stress have been linked with a failure to stop using substances to cope, higher blood sugar levels, greater vulnerability to stressful life events, increased susceptibility to depression, and increased psycho-somatic issues like colds (Cohen, 1994). Control, predictability, social support, coping skills, and personal perception of life events are

related to perceived stress (Sapolsky, 2004). If people feel out of control, then stress levels can increase. Stress can increase if circumstances are not predictable and people are surprised. A lack of social support can increase the level of perceived stress. A lack or absence of positive coping behaviors can increase stress. Finally, perceived stress can increase in a person who views life events negatively or hopelessly (Sapolsky, 2004). COVID-19 is uncontrollable, unpredictable, and fear-inducing. Due to social isolation and lack of social support, normal positive coping behaviors could be impacted. Therefore, increased perceived stress is a viable outcome of COVID-19 (Czeisler et al., 2020; Horesh & Brown, 2020; Malinauskas & Malinauskiene, 2020; Sapolsky, 2004; Szkody et al., 2020).

Theoretical Framework

Perceived Social Support and Mental Health

Perceived social support has been researched to improve mental health (Bareket-Bojmel et al., 2021; Chou et al., 2020; Grey et al., 2020; Grosch & Olson, 2000; Malinauskas & Malinauskiene, 2020; Saltzman et al., 2020). Social support helps buffer adverse events and provides personal security (Freeze, 2017). Perceived social support has been researched to show decreased depression, better sleep, improved hope, fewer cases of loneliness, and less worry during COVID-19 isolation (Bareket-Bojmel et al., 2021; Grey et al., 2020; Saltzman et al., 2020). For instance, strong familial support played an important role in improving mental health during the pandemic (Li & Xu, 2020).

Perceived social support has been researched as a predictor of improved mental health (Bareket-Bojmel et al., 2020; Grey et al., 2020; Li & Xu, 2020). In recent research analysis, perceived social support has been utilized as a mediator (Chou et al., 2020; Malinauskas & Malinauskiene, 2020; Saltzman et al., 2020). A mediator reveals how a predictor variable affects

the outcome variable (Hayes, 2018). In addition, perceived social support has been utilized as a moderator in research (Szkody et al., 2020). A moderator can reveal an interaction between a predictor and an outcome variable (Hayes, 2018).

A gap exists in literature when an interaction is researched between perceived social support and mental health. The current research addresses this gap by studying the interaction of trait emotional intelligence and perceived stress on the relationship between perceived social support and mental health. No investigation was found on this interaction between these variables among any population.

The Interaction of Trait Emotional Intelligence

Emotional intelligence positively predicts mental health (Gutierrez & Mullen, 2016; Vicente-Galindo et al., 2017). Emotional intelligence can help alleviate stress, decrease burnout, and job satisfaction among nurses giving care in Spain during COVID-19 (Soto-Rubio et al., 2020). Given the stress and fatigue that accompany giving care to others, caregivers and local congregations must find ways to prevent low mental health, compassion fatigue, and burnout (Gutierrez & Mullen, 2016). Low emotional intelligence can lead to depression, social dysfunction, anxiety, insomnia, and somatic symptoms like headaches (Vicente-Galindo et al., 2017). These symptoms are comparable to low mental health and low perceived social support (Coppola et al., 2021; Rajkumar, 2020).

Emotional intelligence and mental health are studied among teachers who experience similar environments as church leaders (Merida-Lopez & Extremera, 2017). Church leadership, like teaching, is considered a high-risk profession due to the occupational factors on mental health (Merida-Lopez & Extremera, 2017). Teachers experience stressors like workload, role ambiguity, lack of social support, and people management difficulties (Merida-Lopez &

Extremera, 2017). Emotionally intelligent teachers could have lower stress, role clarity, higher perceptions of social support, and people management strategies (Merida-Lopez & Extremera, 2017). This idea could extend to church leaders and congregations with higher emotional intelligence.

Higher emotional intelligence results in increased social skills, which can strengthen the availability of social support (Bradberry & Greaves, 2009; Gutierrez & Mullen, 2016; Malinauskas & Malinauskiene, 2020; Merida-Lopez & Extremera, 2017). Emotional intelligence is improved and developed through social support and interaction (Goleman, 2006; Malinauskas & Malinauskiene, 2020). This interaction can be attributed to likeability, empathy, self-awareness, and social management (Bradberry & Greaves, 2009). Also, higher emotional intelligence creates an environment for more meaningful social interaction (Malinauskas & Malinauskiene, 2020). Healthier levels of emotional expression, emotional management, optimism, self-esteem, social awareness, stress management, empathy, happiness, optimism, and adaptability can increase social support (Gutierrez & Mullen, 2016; O'Connor et al., 2017; Petrides, 2009; Siegling et al., 2015; Zysberg & Zisberg, 2020).

Emotional intelligence will be measured as an interaction between perceived social support and mental health in this study. Emotional intelligence is most popularly used as a predictor variable (Gutierrez & Mullen, 2016; Malinauskas & Malinauskiene, 2020; Merida-Lopez & Extremera, 2017). Emotional intelligence has been used as a mediator and moderator in research (Sadovyy et al., 2021; Zysberg & Zisberg, 2020). A recent study used emotional intelligence to modulate stress and work performance (Sadovyy et al., 2021). Emotional intelligence did moderate the effect between stress and work performance. Higher emotional intelligence did improve work performance in stressful situations and conditions during COVID-

19 (Sadovyy et al., 2021). This study will evaluate whether emotional intelligence will moderate the effect between perceived social support and mental health during the pandemic. Also, emotional intelligence will be assessed with a secondary moderation of perceived stress. No research was found on this topic. It is unclear how perceived stress will impact trait emotional intelligence.

The Secondary Moderator of Perceived Stress

A secondary moderator is also known as a moderated moderation (Hayes, 2018). In this higher-order interaction, the moderation of the predictor variables' effect on the outcome variable depends on a second moderator (Hayes, 2018). For example, in this study, the moderation of perceived social support on mental health by emotional intelligence depends on perceived stress. Consequently, moderated moderation is also widely known as a three-way interaction since the predictor variable and both moderators interact (Hayes, 2018). There are scant three-way interaction analyses during the COVID-19 pandemic.

Research has indicated that perceived stress harms perceived social support and emotional intelligence (Jiang, 2020; Malinauskas & Malinauskiene, 2020). Alternatively, emotional intelligence has been shown to minimize perceived stress (Malinauskas & Malinauskiene, 2020; Montes-Berges et al., 2007). Another study has shown that perceived stress was buffered during COVID-19 from higher levels of perceived social support (Szkody et al., 2020). No research was found utilizing stress as a moderating moderator for higher-order interaction. In numerous studies, perceived stress has often been used as a predictor variable and mediator (Jiang, 2020; Lee et al., 2016; Malinauskas & Malinauskiene, 2020; Szkody et al., 2020). Regardless, it is evident based on research that stress can strengthen or weaken the

studies' variables of emotional intelligence and perceived social support on mental health (Jiang, 2020; Malinauskas & Malinauskiene, 2020; Montes-Berges et al., 2007; Szkody et al., 2020).

Importance of the Study and Potential Research Gaps

There are mental health concerns among evangelicals and Southern Baptist church members during the COVID-19 pandemic (Czeisler et al., 2020; Daly et al., 2021; Wissing et al., 2021). Mental health concerns include anxiety, depression, stress, and grief (Czeisler et al., 2020; Daly et al., 2021; Eisma, 2020; Ettman et al., 2020; Giuntella et al., 2020; Gunnell et al., 2020; Harms et al., 2017; Kujawa et al., 2020; Simon et al., 2019; Zhai & Du, 2020). A gap exists in the literature understanding the extent and strength of mental health among evangelicals and Southern Baptists during the COVID-19 pandemic. Despite researched mental health challenges associated with COVID-19, little has been written about evangelical, SBC, SBD, and mental health in scholarly research or denominational publications.

Evangelicals can become an extension of God's peace in the world (I Corinthians 12:12-14; Erickson, 2013; Köstenberger, 2010). Alternatively, if church members struggle with mental health challenges, their ministry to the community is severely limited since the congregants will need care themselves. Church leaders have also been negatively impacted by COVID-19 (Stetzer, 2021). If church leaders are struggling themselves, then ministry to their hurting congregation could also be limited. Another significant result of this study is that church leaders' mental health will be evaluated. If the leader is struggling, then the congregation may be as well. If the congregation is hurting, then their caring ministry to the community is limited. The issue may be amplified when little conversation or writing is completed on this subject.

Mental health, perceived social support, trait emotional intelligence, and perceived stress have been significantly understudied concerning evangelicals and Southern Baptists, especially

in quantitative analyses. Research has stated that higher levels of perceived social support have increased mental health during COVID-19 (Grey et al., 2020). Also, higher emotional intelligence has been shown to improve mental health and strengthen perceived social support (Malinauskas & Malinauskiene, 2020). Even though stress has increased during COVID-19, higher emotional intelligence and perceived social support may help decrease perceived stress levels (Malinauskas & Malinauskiene, 2020; Thomas & Barbato, 2020). More research needs to be completed on the effects of stress as it interacts with emotional intelligence, perceived social support, and mental health.

Gaps in current research include mental health analysis among evangelicals; studying mental health, perceived social support, emotional intelligence, and perceived stress among evangelicals and Southern Baptists; researching the COVID-19 virus and its variants' impact on evangelical mental health; the use of quantitative research with the before mentioned variables; and the application of a moderated moderation study using the secondary moderation interaction of perceived stress. The significance of the study will include an evaluation of mental health among evangelical and Southern Baptist church members and leaders to help strengthen awareness, education, and possible healing for deeper care and strengthened community ministry. The proposed study will evaluate the interaction of perceived stress and emotional intelligence on the relationship between perceived social support and mental health among evangelicals in the United States during the COVID-19 pandemic.

Summary

The COVID-19 pandemic has impacted people negatively. Decreased mental health has caused higher anxiety, depression, and suicide rates. Stress and grief are connected to loss, loneliness, and isolation following federal pandemic guidelines to social distance and quarantine.

People are worried and hurting alone. Evangelical and Southern Baptist churches were not immune to decreased mental health. For example, as SBC numbers declined, so did mental health. Little research has been completed on evangelicals or Southern Baptists and mental health, especially during the COVID-19 pandemic. No study sought the relationship between perceived stress, emotional intelligence, perceived social support, and mental health. Quantitative research lacks in evangelicalism concerning mental health overall, and little has been completed on mental health during the COVID-19 pandemic among Southern Baptist church members.

The purpose of this quantitative research is to evaluate the interaction of perceived stress and emotional intelligence on the relationship between perceived social support and mental health among evangelicals in the United States during the COVID-19 pandemic. The current proposed study addresses this gap in the literature through empirical research among evangelical and Southern Baptist church members during the COVID-19 pandemic. The proposed research will also address the gap in quantitative analysis. The proposed research will evaluate the interaction of perceived stress and emotional intelligence on perceived social support and mental health using moderated moderation quantitative analysis. The study will utilize a sample of adult Southern Baptists in the United States, where no empirical evidence was found with this population on this topic. If mental health status can be evaluated with perceived stress, emotional intelligence, and perceived social support, better care and education for evangelicals and Southern Baptists can be proposed. Improved mental health can decrease depression, anxiety, and suicide rates among Southern Baptists to minister to a hurting community. The impacts of this study can reduce fear and bolster enthusiasm for self-care and awareness for specific

caregiving opportunities where the local church is planted and beyond. In the least, conversations can be started on this topic.

CHAPTER THREE: METHODS

Overview

The purpose of this quantitative research is to evaluate the interaction of perceived stress and emotional intelligence on the relationship between perceived social support and mental health among evangelicals in the United States during the COVID-19 pandemic. Moderated moderation, or three-way interaction, was used to explore the interaction of perceived stress and emotional intelligence on the relationship between perceived social support and mental health. This section provides information on the methods of this study. Design, research questions, hypotheses, participants, setting, instrumentation, procedures, and data analysis are discussed.

Design

The study is a quantitative research design utilizing moderated moderation using a convenience sample of Southern Baptists in the United States above 18 years of age (Hayes, 2018; Jackson, 2016; Knight & Tetrault, 2017). Surveys are empirically valid and are used to gather information from a large population (Knight & Tetrault, 2017; Ponto, 2015). To adequately measure the purpose of this study, a quantitative analysis was necessary (Jackson, 2016; Knight & Tetrault, 2017).

The instruments in this research are currently utilized in behavioral science research. Mental health was analyzed using the Mental Health Scale-Short Form (MHC-SF) (Grant, 2021; Lamers et al., 2010; Westerhof & Keyes, 2010). Perceived social support was measured using the Multidimensional Scale of Perceived Social Support Scale (MSPSS) (Grey et al., 2020; Malinauskas & Malinauskiene, 2020; Zimet et al., 1988). The Trait Emotional Intelligence Questionnaire-Short Form (TEIQue-SF) was used to assess emotional intelligence (Gutierrez and Mullen, 2016; O'Connor et al., 2017). Finally, the Perceived Stress Scale (PSS) was used to

assess perceived stress (Cohen, 1994; Lee et al., 2016; Li & Lyu, 2021; Malinauskas & Malinauskiene, 2020). Each of these instruments can be utilized in an online survey format.

Research Variables

The study utilized a moderated moderation model, which included an independent variable (*x*), a primary moderator (*w*), a secondary moderator (*z*), and a dependent variable (*y*) (Hayes, 2018). Perceived social support was the independent variable, trait emotional intelligence was the primary moderator, perceived stress was the secondary moderator, and mental health was the dependent variable. The independent, dependent, and moderating variables were analyzed for statistical significance in this proposed study. The demography of each participant was included to explore gender, age, education level, income level, typical worship service attendance, and race. Factors were controlled to avoid confounds, or alternate explanations, of test results (Warner, 2013). Three covariates were used to avoid confounds. Gender, age, and education level were controlled since these demographic variables have been associated with mental health research (Halpern-Manners et al., 2016; Li &Lyu, 2020; Malinauskas & Malinauskiene, 2020). Data analysis was conducted in SPSS.

External and Internal Validity

External and internal validity was evaluated along with statistical conclusion validity. External validity generalizes finding to different times and populations (Heppner et al., 2016; Jackson, 2016). As a sample of evangelicals, some Southern Baptist people may have limited access to a computer or access the Google link through an email. Also, environmental factors may vary among participants. Some people may complete the survey in a peaceful environment, while others may be in a chaotic environment. Completion instructions were clear to minimize eternal validity threats.

Internal validity is the study's ability to eliminate alternate explanations in the research (Heppner et al., 2016; Jackson, 2016). Internal validity is related to a Type 1 error, and alternative explanations must be minimized (Warner, 2013). The instruments utilized contain empirical support (Gutierrez and Mullen, 2016; Lamers et al., 2010; Siegling et al., 2015; Zimet et al., 1988). Also, history might not be an issue since the data was collected quickly for a few days. Alternatively, a catastrophic event could occur amid the COVID-19 pandemic during testing, creating a disparity in results. A significant event could occur immediately before testing as well.

Statistical Conclusion Validity

Statistical conclusion validity results in an accurate conclusion of variable relationship and interaction (Heppner et al., 2016). Sufficient sample size was gathered of at least 400 people to avoid related issues to low power (Faul et al., 2007). Data analysis investigated outliers, linear relationships, multi-collinearity, and scores' normal distribution of scores (Shavelson, 1996; Warner, 2013). Unreliable test measures were not an issue due to the psychometric accuracy and reliability of the instruments (Gutierrez and Mullen, 2016; Lamers et al., 2010; Siegling et al., 2015; Zimet et al., 1988). Participants could have experienced environmental differences when taking the survey since this research was not an experimental design.

Research Questions

- **RQ1:** Is perceived social support significantly related to the mental health of evangelicals during the COVID-19 pandemic?
- **RQ2:** How does the interaction of perceived social support and mental health depend on emotional intelligence?

- **RQ3:** How does the interaction of perceived social support and mental health depend on perceived stress?
- **RQ4:** What effect does emotional intelligence have on mental health?
- **RQ5:** What effect does perceived stress have on mental health?
- **RQ6:** What effects do emotional intelligence and perceived stress have on mental health?
- **RQ7:** How do the interaction of perceived social support, emotional intelligence, and mental health depend on perceived stress?

Hypotheses

H1: Perceived social support has a direct positive relationship with mental health. Social support has been shown to decrease issues in mental health (Freeze, 2017; Lutz & Eagle, 2019; Malinauskas & Malinauskiene, 2020). In addition, social support can help buffer the negative impact of complex life events, as noted in COVID-19, by providing safety and security (Feeney & Collins, 2015; Freeze, 2017). Perceived social support can be a better indicator of increased mental health than an objective reality of social support (Zimet et al., 1988).

H2: The relationship between perceived social support and mental health is moderated by emotional intelligence. Trait emotional intelligence can be identified with adaptability, assertiveness, emotional perception, impulsiveness, emotional management, self-esteem, social awareness, stress management, and optimism (Gutierrez & Mullen, 2016; O'Connor et al., 2017; Petrides, 2009; Siegling et al., 2015; Zysberg & Zisberg, 2020). People with higher emotional intelligence tend to have more significant indications of mental health (Goleman, 2006; Malinauskas & Malinauskiene, 2020; Scazzero, 2015). Mental health can be

maintained with lower stress levels and higher perceived support with higher emotional intelligence (Malinauskas & Malinauskiene, 2020).

Lower emotional intelligence can be identified in many issues, including withdrawal, social problems, anxiety, depression, attention deficits, memory issues, or aggressive tendencies (Goleman, 2006). In addition, research has indicated a correlation between emotional intelligence and mental health (Malinauskas & Malinauskiene, 2020). Lower emotional intelligence can decrease mental health (Goleman, 2006). Decreased mental health may be evident with lower stress levels and higher perceived support when one has less emotional intelligence (Malinauskas & Malinauskiene, 2020).

H3: The relationship between perceived social support and mental health is moderated by perceived stress. Perceived stress has increased in the United States since the beginning of the COVID-19 pandemic (Czeisler et al., 2020; Horesh & Brown, 2020; Szkody et al., 2020). Conversely, well-being, life satisfaction, and happiness are associated with levels of lessened perceived stress (Malinauskas & Malinauskiene, 2020). In line with studying evangelicals, religious coping has been associated with lower perceived stress when dealing with complex outcomes during COVID-19 (Thomas & Barbato, 2020).

Higher levels of perceived stress during COVID-19 have been attributed to fear of the virus, social isolation, lack of emotional coping behaviors, grief, financial concerns, depression, and anxiety (Czeisler et al., 2020; Horesh & Brown, 2020; Malinauskas & Malinauskiene, 2020; Szkody et al., 2020). In addition, perceived stress can negatively affect perceived social support and emotional intelligence (Malinauskas & Malinauskiene, 2020). COVID-19 is uncontrollable, unpredictable, and fear-inducing. Due to social isolation and lack of social support, normal positive coping behaviors could be impacted. Therefore, increased perceived stress is a viable

outcome of COVID-19 (Czeisler et al., 2020; Horesh & Brown, 2020; Malinauskas & Malinauskiene, 2020; Sapolsky, 2004; Szkody et al., 2020).

H4: Perceived stress moderates the interaction of emotional intelligence on perceived social support and mental health. Research has indicated that perceived stress harms perceived social support and emotional intelligence (Jiang, 2020; Malinauskas & Malinauskiene, 2020). Stress can strengthen or weaken the studies' variables of emotional intelligence and perceived social support on mental health (Jiang, 2020; Malinauskas & Malinauskiene, 2020; Montes-Berges et al., 2007; Szkody et al., 2020).

Participants and Setting

There are over 47,000 local Southern Baptist congregations in the United States (Fahmy, 2019). Participants in this study were a convenience sample of adult Southern Baptists in the United States. Participants were at least 18 years of age. Participants were voluntarily recruited through email, Facebook, and Southern Baptist state convention contacts. The sample size included no less than 400 participants (Faul et al., 2007). Surveys were collected online through email and Facebook. Online surveys were emailed, organized, compiled, organized, and managed via Google Forms. Informed consent was requested before participation (Jackson, 2016).

A quantitative study utilizing surveys is imperative (Ponto, 2015). Therefore, a non-experimental design was applied to a convenience sample of SBC local church members as affiliated with evangelicalism (Warner, 2013). A non-experimental survey design was appropriate with the participant's time and financial restrictions (Creswell, 2003). No compensation was provided for completing the assessments. Ideally, the participants included

individuals from various cultural, ethnic, regional, and socioeconomic backgrounds (Heppner et al., 2016).

Instrumentation

Demographics Screening

Southern Baptist adult participant information was gathered following the consent agreement, including gender, age, education level, income level, church attendance, and race. The covariates utilized in research are present in the demographic analysis. All instruments took less than15 minutes to complete.

The Mental Health Scale-Short Form

Mental health was analyzed using the Mental Health Scale-Short Form (MHC-SF). The MHC-SF is a 14-item self-report that provides a scale to measure flourishing, languishing, or moderately mentally healthy (Grant, 2021; Lamers et al., 2010; Westerhof & Keyes, 2010; Wissing et al., 2019). Each item is rated on a seven-point Likert-type scale ranging from 1 (i.e., never) to 6 (i.e., every day). Sample questions include, “During the past month, how often did you feel happy” and, “During the past month, how often did you feel satisfied with life” (Keyes, 2009). The MHC-SF has shown solid internal consistency of >.80 in adults with good test-retest reliability (Keyes, 2009; Westerhof & Keyes, 2010). Thus, higher scores on the scale reflect an increased level of mental health.

The Multidimensional Scale of Perceived Social Support Scale

Perceived social support was measured using the Multidimensional Scale of Perceived Social Support Scale (MSPSS). The survey is a 12-item self-report that provides subscales based on significant other, family, and friend social support (Zimet et al., 1988). Sample questions include, “There is a special person who is around when I am in need” and, “My family really

tries to help me" (Zimet et al., 1988). Each item is rated on a seven-point Likert-type scale ranging from 1 (i.e., very strongly disagree) to 7 (i.e., very strongly agree). The assessment has a solid internal consistency of .88 (Zimet et al., 1988). In addition, the test-retest reliability was .85 with moderate construct validity (Zimet et al., 1988). Thus, higher scores on the scale reflect an increased level of perceived social support.

The Trait Emotional Intelligence Questionnaire-Short Form

In the research, the Trait Emotional Intelligence Questionnaire-Short Form (TEIQue-SF) was used to assess emotional intelligence. The survey is a 30-item self-report that provides subscale scores based on well-being, self-control, emotionality, sociability, and global trait (Gutierrez & Mullen, 2016). Sample questions include, "I often find it difficult to see things from another person's viewpoint" and, "I usually find it difficult to regulate my emotions" (Petrides, 2009). The TEIQue-SF utilizes a seven-point Likert-type scale ranging from "completely disagree" (i.e., 1) to "completely agree" (i.e., 7). The assessment has a strong internal consistency of .89 (Gutierrez & Mullen, 2016; O'Connor et al., 2017; Petrides, 2009; Siegling et al., 2015; Zysberg & Zisberg, 2020). Half of the questions require reverse scoring (Petrides, 2009). Higher scores indicate a higher degree of global trait or subscales in emotional intelligence (Gutierrez & Mullen, 2016). Internal consistency has been researched to be strong, with alpha coefficients ranging from .87-.89 (Cooper & Petrides, 2010). Also, solid incremental validity has been found (Andrei et al., 2016).

The Perceived Stress Scale

The Perceived Stress Scale (PSS) measured the perception of stress (Cohen, 1994). The instrument consists of 10 items that will evaluate the participant's responses to unpredictability, control, and overload in life that may evoke a stress response (Malinauskas & Malinauskiene,

2020). Sample questions include, “In the last month, how often have you been upset because of something that happened unexpectedly?” and, “In the last month, how often have you felt nervous or ‘stressed’?” (Cohen, 1994). The PSS utilized a 5-point Likert-type scale ranging from “never” (i.e., 0) to “very often” (i.e., 4). The PSS has a consistent internal value of 0.90 with a coefficient value of 0.88 (Malinauskas & Malinauskiene, 2020). Research has indicated that the PSS has good psychometric properties (Lee, 2012). Higher scores indicate a higher degree of perceived stress.

Procedures

This study was proposed to the Liberty University Institutional Review Board (IRB) in Fall 2021. IRB approval was provided in Spring 2022. Participants were voluntarily recruited through email, Facebook, and Southern Baptist state convention contacts in the United States. Online surveys were emailed, organized, compiled, organized, and collected via Google Forms. To protect the identity of the participants, the surveys were given an identification number corresponding across all surveys. Following IRB approval, results were confidentially gathered through Google forms. Southern Baptist church members will receive an email with instructions, a consent form, and a link to complete the assessments.

An agreement for consent to the study was procured in Google Forms© requesting participation in this research. The surveys were distributed through email and Facebook™. An attached consent form in Google Forms© was presented with a clear invitation to the research, benefits of the study, confidentiality assurance, and the amount of time to complete all surveys (see Appendix A). At the beginning of the Google Forms© survey, the participant was asked to consent to the study. If the person did not agree to the research parameters, the participant could not access the demographic or survey data. Also, along with consent, participants were asked if

they were members of a Southern Baptist local congregation in the United States and were at least 18 years of age. If the person was not a Southern Baptist in the United States or younger than 18, the participant could not access the demography or survey portions.

Participants accessed the survey through Google Forms© after agreeing to the consent form and meeting inclusion criteria. Google Forms© guided the participants in the following order: Consent agreement, adult SBC member affirmation, demographic section, MHC-SF, MSPSS, TEIQue-SF, and PSS. The participant could not move to the next section until all questions were answered. Likewise, the survey could not be submitted until all required questions were completed.

Once participants completed the survey, they were instructed to submit the instrument. Once submitted, the Google Form© data was transferred to a Microsoft Excel© Document before SPSS analysis. For statistical power, a sufficient sample size was gathered. This sample included at least 400 people (Faul et al., 2007). Data analysis investigated whether the scores were approximately normally distributed (Warner, 2013). Outliers were excluded. Demographic screening included gender, age, education level, income level, church attendance, and race. Data analysis was conducted through SPSS. Data on a computer will be kept on the researcher's computer, which is password protected, for less than three years. Issues in external and internal validity were considered.

Data Analysis

Data analysis was conducted through the PROCESS macro in SPSS (Hayes, 2018). The PROCESS macro analyzed three-way interactions or moderated moderation (Hayes, 2018). Error information, *t* values, *p* values, direct effects, indirect effects, two-way interactions, and three-way interactions were included (Hayes, 2018). The proposed hypotheses were researched

through models one and three of the PROCESS macro (Hayes, 2018). Model one is a single moderation analysis, and model three contains a three-way analysis. Data screening was completed for all variables to avoid violation of assumptions, identify outliers, and assess for missing values.

Summary

The research evaluated the interaction of perceived stress and emotional intelligence on the relationship between perceived social support and mental health among evangelicals in the United States during the COVID-19 pandemic. This section provided information on the methods of this study. Design, research questions, participants, setting, instrumentation, procedures, and data analysis were discussed. Overall, the research has the potential for new development in counseling research, especially among evangelicals.

CHAPTER FOUR: FINDINGS

Overview

The purpose of this quantitative research is to evaluate the interaction of perceived stress and emotional intelligence on the relationship between perceived social support and mental health among evangelicals in the United States during the COVID-19 pandemic. This chapter discusses significant research findings for this present study. This chapter covers data screening, participant demographics, data analysis, and correlations. Additionally, a summary of the results will be associated with the hypotheses and research questions.

Data Screening

Data was collected through an online survey over eleven days through Google Forms©. The data was transferred to SPSS following the scoring of the assessments from Microsoft Excel©. The information was reviewed for accuracy in SPSS. The data were screened for missing values, ranging from responses, outliers, discrepancy, leverage, multi-collinearity, and assumptions of normality. There were no missing values since the Google Forms© settings were configured to require responses before survey submission. All values were within range.

Outliers were analyzed using Mahalanobis *d*, Cook's distance, and leverage (Warner, 2013). Multivariate outliers were identified and deleted if there was an agreement with at least two of the assessments. Additionally, multicollinearity was assessed through correlation, tolerance, and VIF (Variance Inflation Factor). Multicollinearity was in an acceptable range. Table 1 provides collinearity information. Finally, the results were linear, and assumptions were met. After screening, the total sample size was 432 participants.

Table 1

Collinearity Statistics

Measure	Tolerance	VIF
Perceived Social Support	.5290	1.0990
Emotional Intelligence	.4920	2.0320
Perceived Stress	.8590	1.1640
Gender	.9100	1.0990
Age	.8760	1.1410
Highest Level of Education	.8590	1.1640

*Dependent Variable: Mental Health

Participant Demographics

Of the 432 participants, 229 (53%) identified as male, and 203 (47%) identified as female. Each participant identified as a Southern Baptist church member in the United States. Participants were at least 18 years of age. The mean age was between 41 and 55 years of age. Almost 35% of the participants were 41 to 55 years old (*n*=149), and nearly 39% identified as 56-74 years of age (*n*=166). Other age ranges included participants identified as 26-40 years old (*n*=97, 22.5%) and over 75 years of age (*n*=20, 4.6%).

Of the participants, 416 identified as Caucasian or White (96.3%). Almost 4% identified as either African American, black, or brown (*n*=11, 2.5%) and Asian (*n*=5, 1.2%). All participants identified as having a high school diploma or equivalent degree (i.e., GED). Participants either completed high school or equivalent (*n*=51, 11.8%), trade or vocational school (*n*=34, 7.9%), or a bachelor's degree (*n*=92, 21.3%). Almost 25% completed a terminal degree (*n*=107) and over 34% completed a master's degree (*n*=148). Table 2 provides demographic information for the participants.

Table 2

Participants' Gender, Age, and Race

	N	%
Gender		
Male	229	53.0
Female	203	47.0
Age		
26-40	97	22.5
41-55	149	34.5
56-74	166	38.4
75+	20	4.6
Race		
Caucasian/White	416	96.3
African American/Black/Brown	11	2.5
Asian	5	1.2

Demographic information included annual income. The largest group of participants identified as higher wage earners of over $100,000.00 (*n*=145, 33.6%). Over 40% identified as earning $60,000.00 to $99,999.00 (*n*=175). The remainder of cases earned less than $60,000.00 (*n*=112, 25.9%).

A typical Sunday church attendance was assessed for the participants. 44 (10.2%) stated that the attendance was between 2 and 74, 99 (22.9%) noted the attendance was between 75 and 149, and 66 (15.3%) stated that the typical Sunday church attendance was between 150 to 249 congregants. The highest group of participants identified as congregants of a worship attendance between 250 and 499 (*n*=118, 27.3%). Almost 25% (*n*=105) of the participants stated that the

typical Sunday church attendance was over 500 people. Finally, 115 (26.6%) participants identified as part-time or full-time Southern Baptist vocational ministers. Table 3 provides the additional demographic information for the participants.

Table 3

Participant Demographics

	N	%
Highest Education Completed		
High School or Equivalent	51	11.8
Trade/Tech/Vocational	34	7.9
Bachelor's	92	21.3
Master's	148	34.3
Doctorate	107	24.8
Annual Income		
Less than $10,000	11	2.5
$10,000 to 24,999	6	1.4
$25,000 to 39,999	36	8.3
$40,000 to 59,999	59	13.7
$60,0000 to 79,999	97	22.5
$80,000 to 99,999	78	18.1
Over $100,000	145	33.6
Typical Sunday Church Attendance		
2-74	44	10.2
75-149	99	22.9
150-249	66	15.3
250-499	118	27.3
500-849	60	13.9

	N	%
Over 850	45	10.4
In Part-Time or Full-Time Southern Baptist Vocational Ministry		
Yes	115	26.6
No	317	73.4

Data Analysis

Data was collected by Google Forms© and transferred to Microsoft Excel© for scoring. Once the surveys were scored, the data was transferred to SPSS, version 28.0. Once the data was entered, it was reviewed for accuracy. Reverse coding was necessary for 15 items in the TEIQue-SF. Data analysis was completed using Hayes' (2018) PROCESS macro in SPSS. A three-way, or moderated moderation, analysis was conducted with Model 3. Conditioning values were examined at positive and negative standard deviations (i.e., +1SD, 0, -1SD). Values were mean centered with 5,000 bootstrap samples (Hayes, 2018; Warner, 2013). Other moderation was analyzed using Hayes' (2018) model 1 with TEIQue-SF and PSS as single moderators. Descriptive statistics for each study variable were analyzed, including four scale variables and three nominal covariate variables. Table 4 provides the range, minimum score, maximum score, mean, and standard deviation of the seven variables.

Table 4

Descriptive Statistics

Measure	Range	Minimum	Maximum	Mean	*SD*
Mental Health	51.00	16.00	67.00	48.92	10.12
Perceived Social Support	71.00	13.00	84.00	69.84	14.57
Emotional Intelligence	3.03	3.43	6.47	5.23	0.67

Measure	Range	Minimum	Maximum	Mean	*SD*
Perceived Stress	17.00	13.00	30.00	21.68	3.45
Gender	1.00	0.00	1.00	0.47	0.50
Age	3.00	1.00	4.00	2.25	0.86
Highest Level of Education	5.00	1.00	6.00	3.77	1.59

Correlations

The relationship between variables was conducted through correlation analysis. Significance and Pearson's *r* values can be found in table 5 below. There were higher linear trends between MSPSS (perceived social support) to MHC-SF (mental health) and TEIQue-SF (trait emotional intelligence) to MHC-SF. The study attempted to research four hypotheses and answer seven research questions. The following sections will present the findings.

Table 5

Correlations

Measure	1	2	3	4	5	6	7
Mental Health (1)	1	.737**	.706**	-.109*	.011	.229**	.079
Perceived Social Support (2)	.737**	1	.676**	-.016	-.114*	-.009	.120*
Emotional Intelligence (3)	.706**	.676**	1	-.170**	-.148**	.056	.220**
Perceived Stress (4)	-.109*	.016	-.170**	1	.142**	-.292**	.083
Gender (5)	.011	-.114*	-.148**	.142**	1	-.104*	-.214**
Age (6)	.229**	-.009	.056	-.292**	-.104*	1	-.292**
Highest Level of Education (7)	0.079	.120*	.220**	.083	-.214**	-.292**	1

*Correlation is significant at the .05 level (2-tailed).
**Correlation is significant at the .01 level (2-tailed).

Results

Hypotheses were researched through regression analysis. Each hypothesis evaluated relationships between predictor variables and the outcome variable. Age, gender, and the highest level of education were covariates for the design to protect against confounds (Warner, 2013). Hayes' (2018) PROCESS macro models 1 and 3 were used for analysis to differentiate between the moderating effects of trait emotional intelligence and perceived stress.

Hypothesis 1

The first hypothesis stated that perceived social support has a direct positive relationship with mental health. Overall, the three-way analysis had significant interactions, $F(10, 421) = 102.44$, $p < .001$, $R^2 = .71$. The correlation between perceived social support and mental health was high (Pearson's $r = +.74$). The relationship between perceived social support and mental health was also significant, $b = .2805$, $t(10, 421) = 9.34$, $p = < .001$. The covariates of gender and age were significant in the three-way analysis. Covariate research is found in table 6. The covariate of education was not statistically significant. Research hypothesis one was supported. As perceived social support increased, the mental health score increased. As perceived social support decreased, the mental health score decreased.

Table 6

Covariate Analysis for Three-Way Moderation

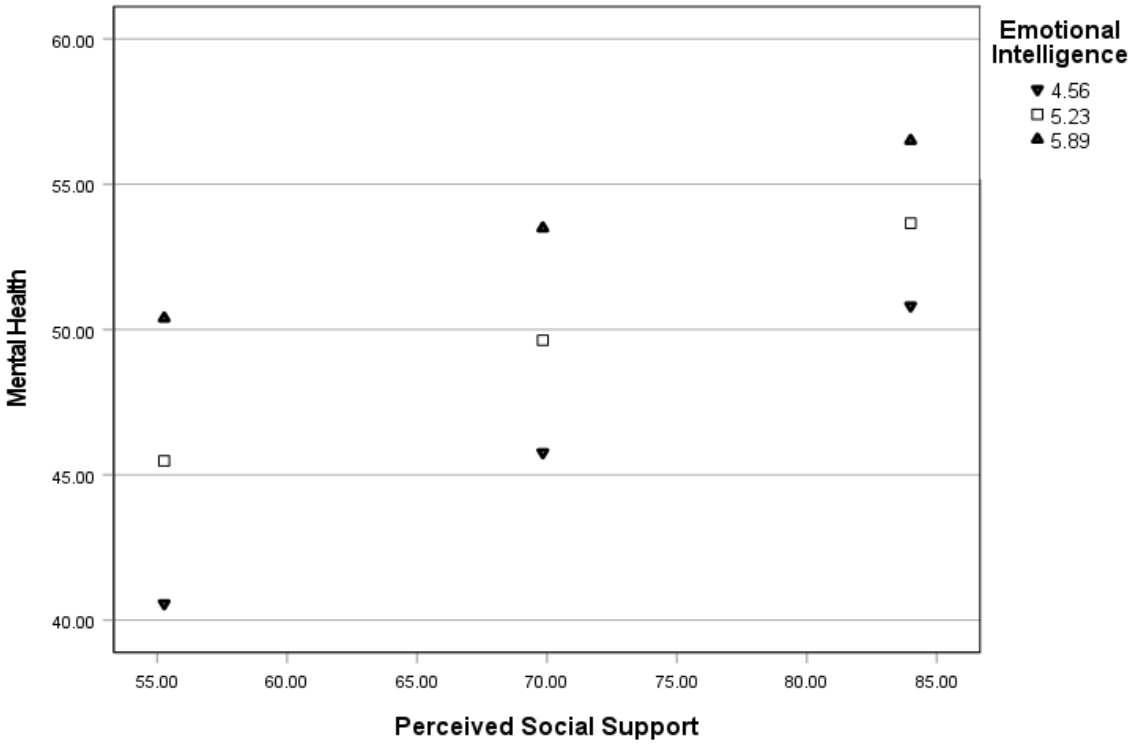
Variable	Coeff	se	*t*	*p*
Gender	3.196	.581	5.503	< .001
Age	2.686	.337	7.967	< .001
Education	-.013	.183	-.171	.943

Hypothesis 2

Hayes' (2018) model one was used to research the second hypothesis. Emotional intelligence was the moderator between perceived social support and mental health. The model one analysis had significant interactions, $F(6, 425) = 166.66$, $p < .001$, $R^2 = .71$. The covariates of gender and age were significant along with perceived social support, $b = .2847$, $t(6, 425) = 9.77$, $p = < .001$, and trait emotional intelligence, $b = 5.8033$, $t(6,425) = 10.32$, $p = < .001$. Emotional intelligence did have a moderating effect on perceived social support and mental health. See figure 1 to see the moderation effect. The interaction of perceived social support and emotional intelligence was significant, $b = -.1082$, $t(6,425) = -4.29$, $p = < .001$, even though the effect was small and negative. The research hypothesis is supported. Higher levels of emotional intelligence strengthened the relationship between perceived social support and mental health. Lower levels of emotional intelligence weakened the relationship between perceived social support and mental health.

Figure 1

The Moderating Effect of Emotional Intelligence



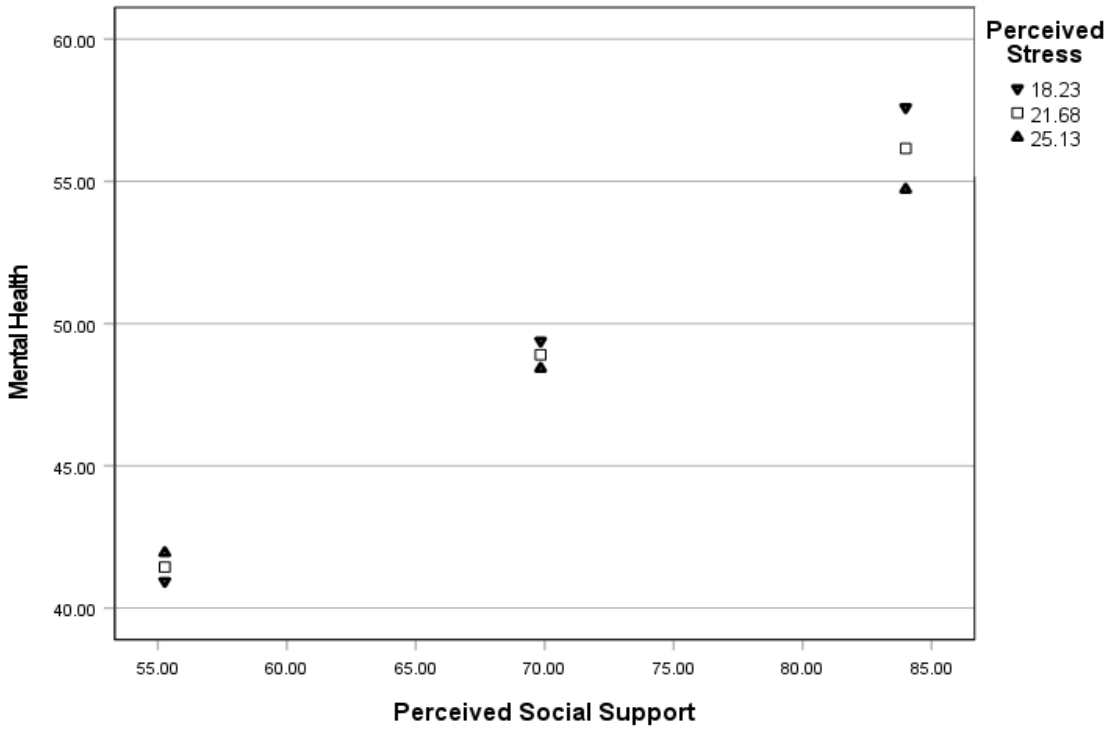
Hypothesis 3

Hayes' (2018) model one was used to research the third hypothesis. Perceived stress was the moderator between perceived social support and mental health. The model one analysis had significant interactions, $F(6, 425) = 119.12$, $p < .001$, $R^2 = .63$. The covariates of gender, age, and highest level of education completed were significant along with perceived social support, $b = .5122$, $t(6, 425) = 24.49$, $p = < .001$. Perceived stress was not statistically significant, $b = -.1404$, $t(6, 425) = -1.52$, $p = .1268$. Perceived stress did have a moderating effect on perceived social support and mental health. See figure 2 to see the moderation effect. The interaction of perceived social support and perceived stress was significant, $b = -.0196$, $t(6, 425) = -3.03$, $p = < .05$, even though the effect was small and negative. Higher stress levels were inversely

proportional to higher perceived social support and mental health levels. The research hypothesis is supported. Higher levels of perceived stress weakened the relationship between perceived social support and mental health. Lower levels of perceived stress strengthened the relationship between perceived social support and mental health.

Figure 2

The Moderating Effect of Perceived Stress



Hypothesis 4

Hayes' (2018) model three was used to analyze the moderating effects of perceived stress on the interaction of emotional intelligence on perceived social support and mental health. The interaction was small and slightly significant, $b = .0252$, $t(10, 421) = 1.97$, $p = .05$. Another way to research this interaction is to review the conditional effects of the focal predictor values of the moderators. Both moderators were analyzed at +1SD, 0, and -1SD and compared at different

interactions (Hayes, 2018). The moderation effect is significant, $p = < .05$, based on the relational impact on perceived social support and mental health. Table 7 presents the results. The research hypothesis is supported since perceived stress moderates the interaction of emotional intelligence on perceived social support and mental health. For instance, higher levels of stress with lower levels of emotional intelligence weakened the relationship between perceived social support and mental health. Lower levels of stress strengthened the relationship between perceived social support and mental health dependent upon the level of emotional intelligence. An average or high level of emotional intelligence attenuated the effect of stress on the relationship between perceived social support and mental health.

Table 7

Conditional Effects on Focal Predictor Values

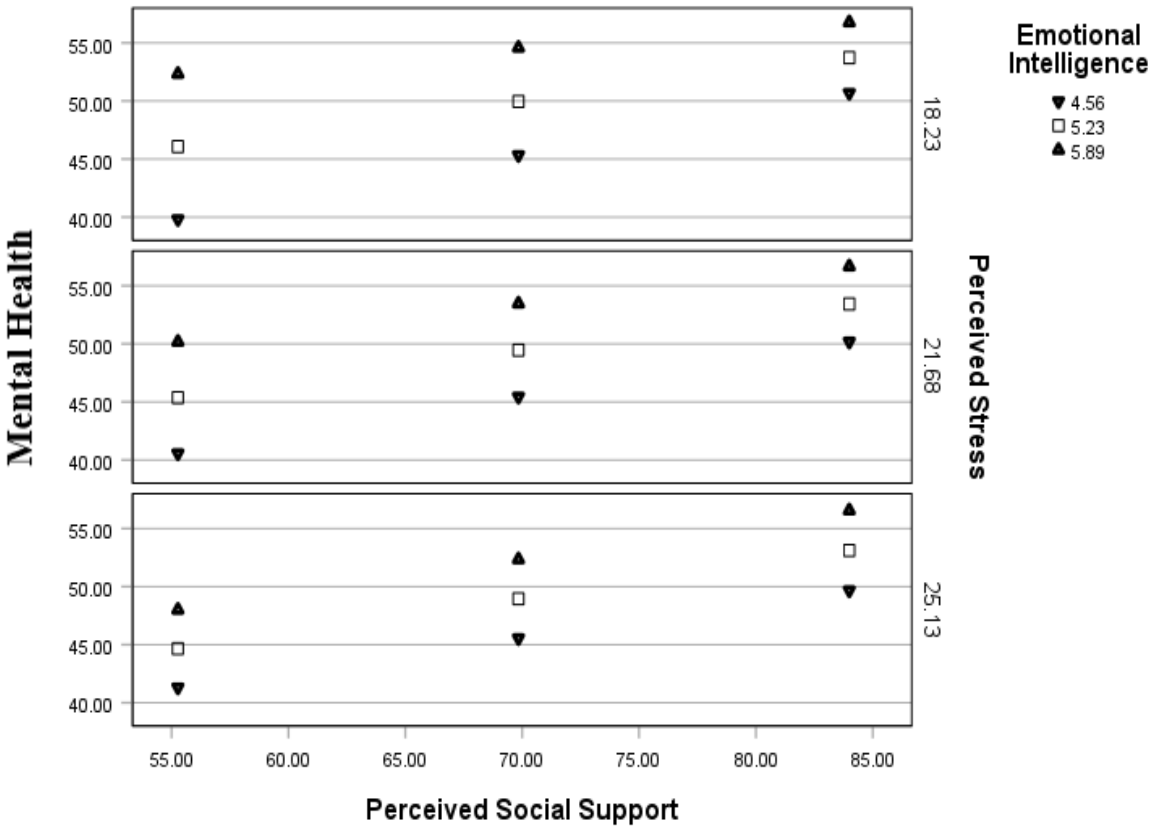
Emotional Intelligence	Perceived Stress	Effect on Perceived Social Support and Mental Health
Low, -.6654	Low, -3.45	Significant Effect, .3786
Low, -.6654	Average, .00	Significant Effect, .3348
Low, -.6654	High, 3.45	Significant Effect, .2910
Average, .0000	Low, -3.45	Significant Effect, .2665
Average, .0000	Average, .00	Significant Effect, .2805
Average, .0000	High, 3.45	Significant Effect, .2944
High, .6654	Low, -3.45	Significant Effect, .1545
High, .6654	Average, .00	Significant Effect, .2262
High, .6654	High, 3.45	Significant Effect, .2979

Figure 3 is a visual representation of table 7. Higher levels of stress have greater impact on lower levels of mental health and perceived social support. Lower levels of stress have less

impact on higher levels of mental health and perceived social support. Perceived stress is attenuated by increased levels of emotional intelligence. Higher levels of perceived stress had greater negative impact on mental health and perceived social support and mental health with decreased levels of emotional intelligence.

Figure 3

The Interaction of Perceived Stress, Emotional Intelligence, and Perceived Social Support



Hypotheses Summary

Hypotheses one, two, three, and four were supported in this analysis. In hypothesis one, perceived social support has a direct positive relationship with mental health. In the second hypothesis, emotional intelligence was the moderator between perceived social support and mental health. In hypothesis three, perceived stress moderates perceived social support and mental health. Finally, in hypothesis four, perceived stress moderated the interaction of

emotional intelligence on perceived social support and mental health among this sample of evangelicals.

Research Questions Findings

The results and analyses of each research question are in this section. There are seven research questions. Each question corresponds to a relationship between the predictor and outcome variables. Questions one, four, and five evaluate the effect of a single predictor variable. Questions two, three, four, and six analyze the effect of interactions as predictors of the outcome variable, mental health. Question seven evaluates the conditional effects of perceived stress (Hayes, 2018). The covariates of gender, $b = 3.1961$, $t(10, 421) = 5.51$, $p = < .001$, and age, $b = 2.6859$, $t(10, 421) = 7.97$, $p = < .001$, were significant in the three-way analysis reflected in the research question findings. The covariate of highest level of education completed, $b = -.0131$, $t(10, 421) = -.0714$, $p = .9431$, was not. Table 8 presents the model three summary findings.

Research Question 1

Is perceived social support significantly related to the mental health of a sample of evangelicals during the COVID-19 pandemic? There is a significant and direct positive relationship between perceived social support, $b = .2805$, $t(10, 421) = 9.34$, $p = < .001$, and mental health. Based on the correlational analysis, perceived social support had the highest positive relationship to mental health (Pearson's $r = +.74$). This was an anticipated outcome based on research (Bareket-Bojmel et al., 2021; Chou et al., 2020; Grey et al., 2020; Grosch & Olson, 2000; Malinauskas & Malinauskiene, 2020; Saltzman et al., 2020).

Research Question 2

How does the interaction of perceived social support and mental health depend on emotional intelligence? In table 8, the findings are presented in the first interaction. The significant interaction effects, b = -.0816, t(10, 421) = -2.99, p = < .05, are slightly negative. The interaction effect was an unanticipated outcome based on research (Gutierrez & Mullen, 2016; Vicente-Galindo et al., 2017).

Research Question 3

How does the interaction of perceived social support and mental health depend on perceived stress? In table 8, the findings are presented in the second interaction. The nonsignificant interaction effects, b = .0040, t(10, 421) = .44, p = .6615, are low. The interaction effect was unanticipated based on the results from hypothesis three that used perceived stress as the direct moderator. In this analysis, perceived stress was the secondary moderator. Scant research is available on this interaction. Research has indicated that perceived stress harms perceived social support and emotional intelligence (Jiang, 2020; Malinauskas & Malinauskiene, 2020). Another study has shown that perceived stress was buffered during COVID-19 from higher levels of perceived social support (Szkody et al., 2020).

Research Question 4

What effect does emotional intelligence have on mental health? There is a significant and direct positive relationship between trait emotional intelligence, b = 6.0249, t(10, 421) = 9.89, p = < .001, and mental health. Based on correlational analysis, trait emotional intelligence had the second-highest positive relationship to mental health (Pearson's r = +.71). This was an anticipated outcome based on research (Coppola et al., 2021; Gutierrez & Mullen, 2016; Merida-Lopez & Extremera, 2017; Rajkumar, 2020; Vicente-Galindo et al., 2017).

Research Question 5

What effect does perceived stress have on mental health? There is a non-significant and negative relationship between perceived stress, b = -.1460, t(10, 421) = -1.36, p = .1750, and mental health. Based on correlational analysis, perceived stress was the only negative relationship to mental health (Pearson's r = -.109). Research suggested that the relationship was negative between perceived stress and mental health; however, the non-significant effect was unanticipated (Czeisler et al., 2020; Horesh & Brown, 2020; Malinauskas & Malinauskiene, 2020; Szkody et al., 2020).

Research Question 6

What effects do emotional intelligence and perceived stress have on mental health? In table 8, the findings are presented in the third interaction. The slightly nonsignificant interaction effects, b = -.3678, t(10, 421) = -1.73, p = .084, are negative. The interaction effect was an anticipated outcome based on research where emotional intelligence has been shown to minimize perceived stress (Malinauskas & Malinauskiene, 2020; Montes-Berges et al., 2007).

Research Question 7

How do the interaction of perceived social support, emotional intelligence, and mental health depend on perceived stress? In table 8, the finding is presented in the fourth interaction. The slightly significant three-way interaction effects, b = .0252, t(10, 421) = 1.97, p = .05, are positive and low. No research was found on the three-way interaction between perceived social support, trait emotional intelligence as primary moderator, and perceived stress as the second moderator. Another way to answer this question is to describe the conditional effects mentioned in hypothesis four and table 7. For instance, lower stress increases the interaction effects of trait emotional intelligence and perceived social support, unless trait emotional intelligence is also

lower, b = .3786, t(10, 421) = 9.91, p = < .001. Higher stress impacts this interaction when emotional intelligence is lower by decreasing the effect of perceived social support on mental health, b = .2910, t(10, 421) = 8.15, p = < .001. As perceived stress and trait emotional intelligence increase, perceived social support more significantly predicts mental health, b = .2979, t(10, 421) = 4.07, p = < .001. Also, as perceived stress and trait emotional intelligence decrease, perceived social support more significantly predicts mental health, b = .3786, t(10, 421) = 9.91, p = < .001.

Table 8

Model 3 Summary

Variable	Effect	SE	*t*	*p*
Perceived Social Support	.281	.030	9.337	< .005
Emotional Intelligence	6.025	.609	9.890	< .005
Interaction of Perceived Social Support and Emotional Intelligence	-.082	.027	-2.989	< .005
Perceived Stress	-.146	.108	-1.359	0.175
Interaction of Perceived Social Support and Perceived Stress	.004	.009	.438	.662
Interaction of Emotional Intelligence and Perceived Stress	-.268	.155	-1.733	.084
Interaction of Perceived Social Support, Emotional Intelligence, and Perceived Stress	.025	.013	1.965	.050
Gender	3.196	.581	5.503	< .005
Age	2.686	.337	7.967	< .005
Highest Level of Education	-.013	.183	-.071	.943

Summary

This quantitative research aimed to evaluate the interaction of perceived stress and emotional intelligence on the relationship between perceived social support and mental health among evangelicals in the United States during the COVID-19 pandemic. This chapter discussed significant research findings for this present study. This chapter covered data screening, participant demographics, data analysis, and correlations. Additionally, a summary of the results was associated with the hypotheses and research questions. Results were presented in each of the four hypotheses and seven research questions. Various tables and figures presented the analysis. The tables and figures were mentioned throughout the chapter. Generally, the resultant findings were significant according to Hayes' (2018) PROCESS macro models 1 and 3 on the sample of evangelicals researched.

CHAPTER FIVE: CONCLUSIONS

Overview

This chapter discusses significant research conclusions for this present study. This chapter discusses the findings from the hypotheses and research questions. Implications, limitations, and recommendations are stated. The research conclusions are collected from the entirety of the research and discussed in this chapter.

Discussion

The purpose of this quantitative research is to evaluate the interaction of perceived stress and emotional intelligence on the relationship between perceived social support and mental health among evangelicals in the United States during the COVID-19 pandemic. To research this topic, an online survey was conducted via Google Forms©. Data was gathered over eleven days to collect 460 surveys. After data screening, 432 survey results were analyzed through SPSS Hayes' (2018) PROCESS macro to research four hypotheses and seven research questions. Perceived social support, trait emotional intelligence, and perceived stress were partially significantly related, $b = .0252$, $t(10, 421) = 1.97$, $p = .05$, to mental health; the moderated moderation was supported. Statistical significance was present in most hypotheses and questions of the analysis.

Perceived Social Support's Impact on Mental Health

Perceived social support involves support given and received between at least two individuals (Zimet et al., 1988). The basic premise is that a person feels supported if cared for and loved by another (Freeze, 2017). Perceived social support includes support from a significant other, friends, and extended family support (Malinauskas & Malinauskiene, 2020; Zimet et al., 1988). A significant other, friend, or family member can provide social support through helping,

serving, listening, caring, and supporting a person in need (Coppola et al., 2021; Grey et al., 2020; Malinauskas & Malinauskiene, 2020). Perceived social support can be a better indicator of increased mental health than an objective reality of social support (Zimet et al., 1988).

Individuals who experienced self-isolation during COVID-19 had statistically significantly higher mental unhealth, depression, and irritability rates than those with higher perceived support (Grey et al., 2020). However, higher perceived support levels significantly lowered depression symptoms and mental unhealth (Grey et al., 2020). Perceived social support has been researched to improve mental health (Bareket-Bojmel et al., 2021; Chou et al., 2020; Grey et al., 2020; Grosch & Olson, 2000; Malinauskas & Malinauskiene, 2020; Saltzman et al., 2020). Social support helps buffer adverse events and provides personal security (Freeze, 2017). Perceived social support has been researched to show decreased depression, better sleep, improved hope, fewer cases of loneliness, and less worry during COVID-19 isolation (Bareket-Bojmel et al., 2021; Grey et al., 2020; Saltzman et al., 2020). In this analysis, 10% of evangelicals' survey cited languishing mental health, and 41% cited moderately mentally healthy (Lamers et al., 2011; Westerhof & Keyes, 2010). The PSS global score was 69.47, which is a high level of perceived social support (Malinauskas & Malinauskiene, 2020). This was expected with a sample from evangelicals and the priority given to social support (Coppola et al., 2021).

Comparatively, this study revealed similar results from recent research. The correlation between perceived social support and mental health was high (Pearson’s r = +.74). The relationship between perceived social support and mental health was significant, b = .2805, t(10, 421) = 9.34, p = < .001. There is a significant and direct positive relationship between perceived social support, b = .2805, t(10, 421) = 9.34, p = < .001, and mental health. Based on correlational analysis, perceived social support had the highest positive relationship to mental health

(Pearson's r = +.74). This analysis and current research show that perceived social support improves mental health. Overall, perceived social support was the highest predictor of mental health among this sample of evangelicals.

The Moderating Effect of Emotional Intelligence

Emotions can be defined as impulses to action (Goleman, 2006). The Latin root word for emotions implies movement (Goleman, 2006). Physical movement and involvement can be derived from fear, anger, happiness, surprise, and sadness (Goleman, 2006). Emotional intelligence is a person's ability to recognize emotions in themselves, discern emotions in others, and healthily manage these emotions (Bradberry & Greaves, 2009; Rice, 2014). Emotional intelligence includes a personal competence and social competence (Gutierrez & Mullen, 2016; Merida-Lopez & Extremera, 2017).

Trait emotional intelligence can be identified with adaptability, assertiveness, emotional perception, impulsiveness, emotional management, self-esteem, social awareness, stress management, and optimism (Gutierrez & Mullen, 2016; O'Connor et al., 2017; Petrides, 2009; Siegling et al., 2015; Zysberg & Zisberg, 2020). Lower emotional intelligence can be identified in many issues, including withdrawal, social problems, anxiety, depression, attention deficits, memory issues, or aggressive tendencies (Goleman, 2006). In addition, research has indicated a correlation between emotional intelligence and mental health (Malinauskas & Malinauskiene, 2020). For example, people with higher emotional intelligence tend to have more significant indications of mental health (Goleman, 2006; Malinauskas & Malinauskiene, 2020; Scazzero, 2015).

Emotional intelligence positively predicts mental health (Gutierrez & Mullen, 2016; Vicente-Galindo et al., 2017). Emotional intelligence can help alleviate stress, decrease burnout,

and job satisfaction during COVID-19 (Soto-Rubio et al., 2020). Low emotional intelligence can lead to depression, social dysfunction, anxiety, insomnia, and somatic symptoms like headaches (Vicente-Galindo et al., 2017). Higher emotional intelligence results in increased social skills, which can strengthen the availability of social support (Bradberry & Greaves, 2009; Gutierrez & Mullen, 2016; Malinauskas & Malinauskiene, 2020; Merida-Lopez & Extremera, 2017). Emotional intelligence is improved and developed through social support and interaction (Goleman, 2006; Malinauskas & Malinauskiene, 2020). Also, higher emotional intelligence creates an environment for more meaningful social interaction (Malinauskas & Malinauskiene, 2020). The average total score on the TEIQue-SF from the general population ranges from 4.94 to 5.18 (Cooper & Petrides, 2010; Gutierrez & Mullen, 2016). The results of the TEIQue-SF in this research were 5.21, moderately higher than the average.

Emotional intelligence is most popularly used as a predictor variable (Gutierrez & Mullen, 2016; Malinauskas & Malinauskiene, 2020; Merida-Lopez & Extremera, 2017). Emotional intelligence has been used as a mediator and moderator in research (Sadovyy et al., 2021; Zysberg & Zisberg, 2020). A recent study used emotional intelligence to modulate stress and work performance (Sadovyy et al., 2021). Emotional intelligence did moderate the effect between stress and work performance. Higher emotional intelligence did improve work performance in stressful situations and conditions during COVID-19 (Sadovyy et al., 2021).

In this study, emotional intelligence was the moderator between perceived social support and mental health. Emotional intelligence, $b = 5.8033$, $t(6, 425) = 10.32$, $p = < .001$, did have a moderating effect on perceived social support and mental health when analysis was completed in a single-moderation analysis. The significant interaction effects, $b = -.0816$, $t(10, 421) = -2.99$,

$p = < .05$, are slightly negative. In the three-way analysis, the interaction of the moderated trait emotional intelligence effect was an unanticipated outcome based on research (Gutierrez & Mullen, 2016; Vicente-Galindo et al., 2017). This could be due to the responses during a pandemic.

For instance, COVID-19 was associated with social distancing, lockdown restrictions, and quarantine expected to have marked and enduring mental health effects (Coppola et al., 2021; Czeisler et al., 2020; Daly et al., 2021). COVID-19 could be considered a traumatic event that increased physical, emotional, and psychological harm (Ettman et al., 2020). Normality is disrupted globally, not just locally. A person's brain and body could be on heightened alert and focused attention (Dlugosz, 2021; Sapolsky, 2004). Chronic states of heightened sensitivity created a foundation for lower levels of well-being and mental health with increased emotional distress (Chapman et al., 2021; Dlugosz, 2021; Margetic et al., 2021).

The Moderating Effect of Perceived Stress

Stress is a natural, expected, and normal response to life's situations, events, and demands (Sapolsky, 2004). Stress refers to the physical and psychological arousal when a person perceives a change in their lives, relationships, expectations, or predictions (Harms et al., 2017). Perceived stress is the degree to which events and situations in a person's life are considered stressful (Cohen, 1994). Perceived stress has increased in the United States since the beginning of the COVID-19 pandemic (Czeisler et al., 2020; Horesh & Brown, 2020; Szkody et al., 2020).

Higher levels of perceived stress during COVID-19 have been attributed to fear of the virus, social isolation, lack of emotional coping behaviors, grief, financial concerns, depression, and anxiety (Czeisler et al., 2020; Horesh & Brown, 2020; Malinauskas & Malinauskiene, 2020; Szkody et al., 2020). In addition, perceived stress can negatively affect perceived social support

and emotional intelligence (Malinauskas & Malinauskiene, 2020). Alternatively, well-being, life satisfaction, and happiness are associated with levels of lessened perceived stress (Malinauskas & Malinauskiene, 2020). In line with studying evangelicals and Southern Baptists, religious coping has been associated with lower perceived stress when dealing with complex outcomes during COVID-19 (Thomas & Barbato, 2020).

COVID-19 was uncontrollable, unpredictable, and fear-inducing. Due to social isolation and lack of social support, normal positive coping behaviors could be impacted. Therefore, increased perceived stress is a viable outcome of COVID-19 (Czeisler et al., 2020; Horesh & Brown, 2020; Malinauskas & Malinauskiene, 2020; Sapolsky, 2004; Szkody et al., 2020). The PSS total score in this study sample was 21.75, which is considered a moderate stress level (Malinauskas & Malinauskiene, 2020).

This research analysis aligned with the research. In a single moderation analysis, perceived stress was the moderator between perceived social support and mental health. The analysis had significant interactions, $F(6, 425) = 119.12$, $p < .001$, $R^2 = .63$ even though perceived stress was not statistically significant, $b = -.1404$, $t(6, 425) = -1.52$, $p = .1268$. In the three-way analysis, perceived stress did have a moderating effect on perceived social support and mental health. The interaction of perceived social support and perceived stress was significant, $b = -.0196$, $t(6, 425) = -3.03$, $p = < .05$, even though the effect was small and negative. Higher stress levels were inversely proportional to higher levels of perceived social support and mental health. However, as perceived social support and mental health increased in a single moderation design, stress had less effect on the relationship between perceived social support and mental health (see Figure 2).

Three-Way Analysis

Even though no research was found using a similar three-way analysis to the variables in this study, there are interesting findings to explore. Research suggested that mental health can be maintained with lower stress levels and higher perceived support when one has higher emotional intelligence (Malinauskas & Malinauskiene, 2020). This research shared some features comparative to research; however, contrasts can be made based on the three-way analysis to assess the moderating effects of perceived stress on the interaction of emotional intelligence on perceived social support and mental health. The interaction in this study was small and slightly significant, $b = .0252$, $t(10, 421) = 1.97$, $p = .05$.

Another way to research this interaction is to review the conditional effects of the focal predictor values of the moderators. Both moderators were analyzed at +1SD, 0, and -1SD and compared at different interactions (Hayes, 2018). The moderation effect is significant, $p = < .05$, based on the relational impact on perceived social support and mental health. Lower stress increased the interaction effects of trait emotional intelligence and perceived social support, unless trait emotional intelligence was lower, $b = .3786$, $t(10, 421) = 9.91$, $p = < .001$. Higher stress impacted the interaction when emotional intelligence was lower by decreasing the effect of perceived social support on mental health, $b = .2910$, $t(10, 421) = 8.15$, $p = < .001$.

As perceived stress and trait emotional intelligence increase, perceived social support more significantly predicted mental health, $b = .2979$, $t(10, 421) = 4.07$, $p = < .001$. Also, as perceived stress and trait emotional intelligence decreased, perceived social support more significantly predicts mental health, $b = .3786$, $t(10, 421) = 9.91$, $p = < .001$. Simply stated, perceived social support had the greatest impact on mental health amid the moderating

interactions. Overall, perceived social support mattered most. This idea aligns with biblical applications (Erickson, 2013; Köstenberger, 2010; Lambert, 2016).

Implications

Research Implications

Despite researched mental health challenges associated with COVID-19, little has been written about evangelicals, SBC, SBD, and mental health in scholarly research or denominational publications. A gap existed in the literature understanding the extent and strength of mental health among evangelicals and Southern Baptists during the COVID-19 pandemic. Additionally, in quantitative analyses, mental health, perceived social support, trait emotional intelligence, and perceived stress have been significantly understudied concerning evangelicals and Southern Baptists. Another gap existed in the absence of a moderated moderation containing the variables of this study. Therefore, the current study contributes to this research among evangelicals in the United States. However, more research must be conducted.

Counseling and Psychology Implications

Because perceived social support can increase mental health, it should be considered in the methodology and treatment of mental unhealth and associated disorders (Coppola et al., 2021; Grey et al., 2020; Malinauskas & Malinauskiene, 2020). Social support has been shown to increase well-being and decrease issues in mental health like depression, anxiety, and stress (Freeze, 2017; Lutz & Eagle, 2019; Malinauskas & Malinauskiene, 2020). In addition, social support can help buffer the negative impact of complex life events by providing safety and security (Feeney & Collins, 2015; Freeze, 2017). Interestingly, perceived social support can be a better indicator of increased mental health than an objective reality of social support (Zimet et al., 1988).

Emotional intelligence is another factor to consider with counseling and psychological implications. As discussed, four essential areas of emotional intelligence include self-awareness, self-management, social awareness, and relational management (Bradberry & Greaves, 2009). Trait emotional intelligence is akin to a personality construct in that a person either has emotional intelligence or does not have emotional intelligence, but it can be developed (Bradberry & Greaves, 2009; Merida-Lopez & Extremera, 2017). Emotional intelligence is linked to adaptability amid traumatic change and increased social skills that can develop more significant levels of social support. In this research, emotional intelligence acted as a buffer to stress.

Another counseling and psychology implication could be around perceiving and coping with stress. In this research, stress was moderately high. Higher levels of perceived stress have been linked with a failure to stop using substances to manage, higher blood sugar levels, greater vulnerability to stressful life events, increased susceptibility to depression, and increased psycho-somatic issues like colds (Cohen, 1994). Control, predictability, social support, coping skills, and personal perception of life events are related to perceived stress (Sapolsky, 2004). Counseling skills that include resilience and coping techniques would be beneficial (Wicks, 2010). According to this study, an average or high amount of stress can benefit an individual with average to high emotional intelligence.

Local Church Implications

Evangelicals can become an extension of God's peace in the world (I Corinthians 12:12-14; Erickson, 2013; Köstenberger, 2010). Alternatively, if church members struggle with mental health challenges, their ministry to the community is severely limited since the congregants will need care themselves. Church leaders have also been negatively impacted by COVID-19

(Stetzer, 2021). If church leaders are struggling themselves, then ministry to their hurting congregation could also be limited.

Church attendance did provide a negligible impact on the predictor and outcome variables. Respondents who stated that their typical church attendance was between 150 to 249 also showed the most significant level of perceived social support (r^2 = .133). Congregants who participated from a church with 500 to 849 in a typical Sunday church attendance indicated the most significant level of emotional intelligence (r^2 = .019). Congregants who participated from a church that had 500 to 849 in a typical Sunday church attendance also showed the lowest levels of perceived stress (r^2 = .0002). Finally, congregants who participated from a church with 500 to 849 in a typical Sunday church attendance indicated the most significant level of mental health (r^2 = .026).

Another significant result of this study is that church leaders' mental health will be evaluated. If the leader is struggling, then the congregation may be as well. If the congregation is hurting, then their caring ministry to the community is limited. The issue may be amplified when little conversation or writing is completed on this subject.

Amid a mental health crisis and suffering from the COVID-19 pandemic, few people live the abundant life promises (John 10:10). However, people can be restored and renewed in Jesus, who provides perfect peace. People who are following Jesus are invited to have the mind of Christ during the painful effects of COVID-19 (I Corinthians 2:16; Philippians 4:8). According to this research, improved perceived social support among evangelical congregations may significantly impact improving mental health.

Limitations

On the first day of data collection, February 24, Russia invaded Ukraine (Fitzgerald, 2022). Historical validity could be a limitation of this study due to this conflict (Heppner et al., 2016; Jackson, 2016). Initially, there was a concern in collecting enough data necessary for this study. Pastors were contacted, urging cooperation among church members to complete the survey. This event could inadvertently create alternate explanations for this research.

Another limitation may include using self-reported data with a convenience sample of Southern Baptists. While data screening was conducted, there is a risk that participants did not provide honest feedback impacting the accuracy of study results. Also, the participants were predominantly Caucasian or White (96.3%). Therefore, the study lacks multiculturalism and race diversity.

The study lacks the internal validity of a pure experimental design (Jackson, 2016). Alternatively, this study was focused on a specific population that would provide more support for external validity (Warner, 2013). The online survey did offer the ability to gather enough data for the analysis but faltered in inviting racial diversity. Racial diversity is also an issue among Southern Baptists (Cagle, 2021; TAB Media, 2021).

Another limitation is that inherent to a correlational design, and correlation does not equal causation. Correlation does not validate that one variable is the primary predictor of another (Jackson, 2016; Warner, 2013). This study supported multiple significant and meaningful relationships; however, it is vital to note that a cause cannot be determined through a non-experimental design (Jackson, 2016; Warner, 2013).

Recommendations for Further Research

Recommendations for further research include evangelical variety, varied quantitative analysis, qualitative research, and an identical survey beyond the Russia and Ukraine conflict. The convenience sample of Southern Baptists in the United States is above 18 years of age (Hayes, 2018; Jackson, 2016; Knight & Tetrault, 2017). Different denominations and non-denominations among evangelicalism could be assessed and evangelicals outside the United States.

A variety of quantitative analyses could be used. In this study, gaps in current research include mental health analysis among a sample of Southern Baptists as affiliated with evangelicalism; studying mental health, perceived social support, emotional intelligence, and perceived stress among Southern Baptists and evangelicals; researching the COVID-19 virus and its variants' impact on evangelical mental health; the use of quantitative research with the before mentioned variables; and the application of a moderated moderation study using the secondary moderation interaction of perceived stress. Overall, there is a need for more quantitative analysis in this population.

Qualitative analysis could be used to validate correlational analysis from this study (Creswell & Poth, 2018). A narrative, phenomenological, or case study research would be appropriate (Creswell & Poth, 2018). For instance, qualitatively assessing the depth of perceived social support, emotional intelligence, perceived stress, and mental health would strengthen this correlational design and add depth to the results (Creswell & Poth, 2018).

There is a validity concern from the war since the data was collected at the beginning stages of the Russian invasion of Ukraine (Fitzgerald, 2022). An identical survey could be collected beyond the conflict to validate the results of this study. In addition, validation may be

needed to verify the relationships between mental health, perceived social support, emotional intelligence, and perceived stress that were discovered in this study's analysis.

Summary

The purpose of this quantitative research was to evaluate the interaction of perceived stress and emotional intelligence on the relationship between perceived social support and mental health among evangelicals in the United States during the COVID-19 pandemic. This chapter discussed significant research conclusions for this present study. Next, this chapter discussed the findings from the hypotheses and research questions. Finally, implications, limitations, and recommendations were stated.

This study attempted to address the gaps of contemporary research among evangelicals, specifically through quantitative analysis. As a result, evangelicals can normalize the conversation about mental health and embrace the truth that God desires for His creation to flourish and be an extension of His grace, hope, and love (Erickson, 2013; Köstenberger, 2010). Implications for comprehension of the impacts of COVID-19 and compassionate care for people who are isolated, alone, and struggling is emphasized. John 16:33 reads, "I [Jesus] have told you these things so that in me you may have peace. In this world you will have trouble. But take heart! I have overcome the world" (NIV).

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APPENDIX A:

CONSENT FORM

Title of the Project: The Interaction of Perceived Stress and Emotional Intelligence on the Relationship Between Perceived Social Support and Mental Health Among Southern Baptist Church Members in the United States During the COVID-19 Pandemic
Principal Investigator: Michael S. Williams, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be a Southern Baptist in the United States of at least 18 years of age. Taking part in this research project is voluntary. Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of the study is to quantitatively evaluate the interaction of perceived stress and emotional intelligence on the relationship between perceived social support and mental health among Southern Baptist church members in the United States during the COVID-19 pandemic. Mental health, perceived social support, emotional intelligence, and perceived stress have been significantly understudied concerning Southern Baptists, especially in quantitative analyses. The significance of the study will include an evaluation of mental health among Southern Baptist members and evangelical leaders to help strengthen awareness, education, and possible healing for deeper care and strengthened community ministry.

What will happen if you take part in this study?

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

1. Plan to answer all the questions in the survey. The entire survey may take 15 minutes to complete.
2. Please submit your responses after your survey. All information will be confidential.

How could you or others benefit from this study?

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

What risks might you experience from being in this study?

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

How will personal information be protected?

The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records. Data on a computer will be kept on the researcher's computer, which is password protected. The results on the survey in Google Forms will be securely stored online and password protected. Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted. Participant responses will be anonymous. Participant responses will be kept confidential through the use of numbers.

How will you be compensated for being part of the study?

Participants will not be compensated for participating in this study.

Is study participation voluntary?

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

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Michael Williams. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at [redacted] You may also contact the researcher's faculty sponsor, Dr. Fred Volk at [redacted]

Whom do you contact if you have questions about your rights as a research participant?

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

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

Before agreeing to be part of the research, please be sure that you understand what the study is about. You can print a copy of this document for your records. If you have any questions about the study later, you can contact the researcher using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

_____

Printed Subject Name

Liberty University
IRB-FY21-22-411
Approved on 2-22-2022

_____

Signature & Date

APPENDIX B:

IRB APPROVAL LETTER

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

February 22, 2022

Michael Williams
Frederick Volk

Re: IRB Exemption - IRB-FY21-22-411 The Interaction of Perceived Stress and Emotional Intelligence on the Relationship between Perceived Social Support and Mental Health among Southern Baptist Church Members in the United States during the COVID-19 Pandemic

Dear Michael Williams, Frederick Volk,

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

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(i). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording).
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects.

Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

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

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

APPENDIX C:

SAMPLE RECRUITMENT EMAIL

Dear Southern Baptist,

As a doctoral student in the School of Behavioral Sciences at Liberty University, I am researching as part of a Doctor of Education degree requirement. The purpose of my research is to evaluate the interaction of perceived stress and emotional intelligence on the relationship between perceived social support and mental health among Southern Baptist church members in the United States during the COVID-19 pandemic. Basically, I want to invite more conversations on the topic of mental health among Southern Baptists and evangelicals. I am writing to invite eligible participants to join my study.

Just like we need a physical health check-up, we need a mental health check-up as well!

Participants must be a member of a Southern Baptist church in the United States and at least 18 years of age. Participants, if willing, will be asked to complete surveys on Google Forms. It should take approximately 15 minutes to complete. Participation will be completely anonymous, and no personal, identifying information will be collected.

The benefits to participation include the possibility of gaining fresh insight and awareness of your personal growth and development.

In order to participate, please click here [link will be provided].

A consent document is provided on the first page of the survey. The consent document contains additional information about my research. You do not need to sign and return the document. You can select “yes” to agree to consent and continue with the survey. Doing so will indicate that you have read the consent information and would like to participate in the survey.

Participation is voluntary, and no compensation is provided.

Thank you for your consideration.

Sincerely,

Michael Williams
Liberty University

APPENDIX D:

SAMPLE RECRUITMENT INFORMATION FOR FACEBOOK

Research Participants Needed!

Title (brief): Mental Health Among Southern Baptists in the United States During COVID-19

Title: Evangelical Mental Health During A Pandemic: A Three-Way Interaction Analysis

Just like people receive physical check-ups, we can have mental health check-ups as well. Basically, I want to invite more conversations on the topic of mental health among Southern Baptists and evangelicals.

Questions:

- Are you 18 years of age or older?
- Are you a member of a Southern Baptist church in the United States?

If you answered "yes," you may be eligible to participate in a mental health research study.

The purpose of this quantitative research is to evaluate the interaction of perceived stress and emotional intelligence on the relationship between perceived social support and mental health among Southern Baptist church members in the United States during the COVID-19 pandemic.

The benefits to participation include the possibility of gaining fresh insight and awareness of your personal growth and development. It should take approximately 15 minutes to complete. Participation will be completely anonymous, and no personal, identifying information will be collected.

In order to participate, please click here [link will be provided].

Michael S. Williams, a doctoral candidate in the Department of Community Care and Counseling at Liberty University, is conducting this study.

APPENDIX E:

ASSESSMENT PERMISSIONS

The Mental Health Scale-Short Form (MHC-SF)

Although copyrighted, the MCH-SF may be used as long as proper credit is given. Permission is not needed to use the measure, and requests to use the measure will not be answered on an individual basis because permission is granted here, and this does not provides evidence that permission has been granted. Proper citation of the document:

Keyes, C. L. M. (2009). Atlanta: *Brief description of the mental health continuum short form (MHC-SF).* Available: http://www.sociology.emory.edu/ckeyes/.

No permission was given to publicize the assessment.

The Multidimensional Scale of Perceived Social Support Scale (MSPSS)

The MSPSS is free to use. Credit the following paper if you use the scale:

Zimet, G., Dahlem, N., Zimet, S., & Farley, G. (1988). The multidimensional scale of perceived social support. *Journal of Personality Assessment, 52*(1), 30-41. https://doi.org/10.1207/s15327752jpa5201_2

No permission was given to publicize the assessment.

The Trait Emotional Intelligence Questionnaire-Short Form (TEIQue-SF)

Provided there is no commercial usage, TEIQue instruments can be used for academic or medical research purposes without permission.

Petrides, K. (2009). Psychometric properties of the Trait Emotional Intelligence Questionnaire. In C. Sough, D. Saklofske, and J. Parker, *Advances in the assessment of emotional*

intelligence. Springer.

No permission was given to publicize the assessment.

The Perceived Stress Scale (PSS)

The items of the scale are available in the appendix of the article by Cohen, Kamarck, and Mermelstein (1983). Alternatively, the PSS can be sourced through a simple search online. No permission is required to use this scale. It was intended to be an economic tool be used for research purposes. The PSS is primarily used in research settings.

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24*(4), 385-396. https://doi.org/10.2307/2136404

No permission was given to publicize the assessment.