THE EFFECTS OF MENTAL HEALTH ON EMOTIONAL INTELLIGENCE AMONG LATINO CHURCH LEADERS

by

Janice Torres

Liberty University

A Dissertation Proposal Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

Liberty University

April 2024

ABSTRACT

Latinos are a culturally based race whose mental health focuses on the foundation established by their cultural upbringing and religion. Stigma, religious values, and culture are essential in Latinos' perspectives regarding their emotional intelligence and mental health. This experimental study investigated the effect of mental health on emotional intelligence in Latino church leaders, utilizing *The Emotionally Healthy Leader* as an intervention. This study employed a pretest-posttest design where participants' emotional intelligence, mental health, and mental health awareness were assessed before and after the intervention. A randomized, controlled trial (RCT) encompassed a group of randomly assigned Latino church leaders who participated in *The Emotionally Healthy Leader* and a controlled group who did not participate in *The Emotionally Healthy Leader*. Quantitative data was collected using validated scales to measure the effect of *The Emotionally Healthy Leader* on mental health, mental health awareness, and emotional intelligence. Descriptive statistics and independent sample t-tests were used for data analysis. Utilizing a mixed-methods approach, this study employed both multivariate and univariate tests to assess the impact of the intervention. Results from multivariate tests reveal a significant effect of the intervention on mental health awareness and emotional intelligence. Univariate tests corroborate these findings, indicating significant improvements in mental health awareness and emotional intelligence awareness, post-intervention. Ethical considerations were addressed, and potential limitations included reliance on self-reporting measures. The results from this research study underscore the potential efficacy of *The Emotionally Healthy Leader* intervention in enhancing mental health awareness and emotional intelligence among Latino church leaders, contributing valuable insights to the literature on promoting emotional intelligence and mental health awareness within this demographic.

Keywords: awareness, emotional intelligence, leader, mental health

Copyright Page

Dedication

I want to dedicate this Dissertation, first and foremost, to my God, my Lord, and my Savior.

By His grace and mercy, I was able to complete this research project and accomplish this milestone.

“Ebenezer, up to this point, the Lord has helped us.” (*New Living Translation*, 2016, 1 Samuel 7:12).

Secondly, I’d like to dedicate this Dissertation to my husband, Ivan, and our children, Nevaeh, Vianice, Mikaela, Isaiah, Leivan, and Leahnie. Their unconditional support and encouragement have been everything I needed throughout this season. I love you all!

Acknowledgments

I thank God for carrying me through every step of the way. I also want to thank my loving husband, Ivan, and our six incredible children. Your understanding, patience, and constant encouragement have driven my pursuit of higher education. Your sacrifices and shared responsibilities allowed me the time and space to focus on my studies. Thank You.

Mom and Dad, thank you for your unending support. Your belief in my potential and your continuous encouragement have been invaluable. Pastor Luis and Adelene Soto and our local church, Iglesia Tampa Bay, thank you for your continued support and prayers. Your spiritual guidance and encouragement gave me the strength and determination to overcome challenges and persevere.

To my academic mentors and professors at Liberty University, thank you for your guidance, expertise, and commitment to fostering a nurturing learning environment. Your dedication to excellence has been a source of inspiration and motivation. Thank you, Dr. Kim and Dr. Beiler, for believing in me and walking me through this season.

I express my deepest gratitude to my friends, family, colleagues, and all those who shared this academic journey with me and have been instrumental in successfully completing this dissertation, a journey that has been both challenging and rewarding. Your support, encouragement, and unwavering belief in my abilities have been the pillars that sustained me throughout this academic endeavor. I am blessed to have such an incredible support system beyond academia. Each of you has played an indispensable role in my academic success, and I am profoundly grateful for your contributions to this significant achievement.

TABLE OF CONTENTS

List of Tables

List of Figures

CHAPTER 1: INTRODUCTION TO THE STUDY

Introduction

Latino church leaders are vital in providing spiritual guidance and support to their congregants (Waglay et al., 2020). Their leadership skills are essential in fostering emotional well-being among their congregants. Leaders who operate in a continuous state of emotional and spiritual deficit are emotionally unhealthy (Scazzero, 2015). Pastors and leaders are part of humanity and are not exempt from struggles with emotional intelligence. Working through their emotional baggage is fundamental to achieving mental and emotional healing to help congregants effectively during crises (Rudolph & Landman, 2019). The conversation among Latino leadership in the church needs to change regarding mental health to help improve mental health awareness and literacy in hopes of decreasing stigma and improving emotional intelligence (Kansiewicz et al., (2021). Limited research exists on the relationship between mental health awareness, mental health, and emotional intelligence, specifically regarding Latino church leaders.

This experimental study aims to fill the gap in research by examining the impact of mental health awareness on mental health and emotional intelligence in Latino church leaders and evaluating the effectiveness of *The Emotionally Healthy Leader* in increasing mental health awareness, mental health, and enhancing emotional intelligence. By exploring the relationship between mental health and emotional intelligence in Latino church leaders, this study seeks to raise awareness about the importance of mental health and emotional intelligence in the context of Latino church leaders and aims to provide insight that can help support the mental health and emotional intelligence of Latino church leaders to benefit them and their congregants.

Background

Emotional Intelligence

Leadership within the church are not seen as humans. However, leaders are not exempt from being morally challenged (Smith, 2020). The pressure of having to live an exemplary life or not being considered to have feelings or emotions can lead an individual in a leadership position to not accurately address matters of self or provide adequate service to others in need (Webb & Chase, 2018). In addition, being in a leadership position can sometimes cause the leader to experience “fog” in the different components of emotional intelligence, including empathy, effective communication, self-awareness, self-regulation, and motivation. (Ming, 2022). The

intersection of mental health and emotional intelligence is an important area of study, as both factors can significantly impact a person's ability to effectively manage emotions, build healthy relationships, and lead effectively by making sound decisions.

Christ created all things in Him, through Him, and for a relationship with Him. The Science of Psychology is a part of God's design for the church to receive help and to help others. It also serves as a platform to help individuals unite and sharpen each other. The call of wisdom appeals to all creation to pay attention and learn from her, for her insight and understanding are genuinely available to them if they need her (Wolters, 2005).

> "So, we have not stopped praying for you since we first heard about you. We ask God to give you complete knowledge of His will and to give you spiritual wisdom and understanding. Then how you live will always honor and please the Lord and your lives will produce every kind of good fruit. You will grow as you learn to know God better and better." (*New Living Translation*, 2015, Colossians 1:9-10).

Dealing with mental health conditions causes complications in life (Cook, 2020). It is difficult to maintain the state of one's heart aligned with living a life of wisdom and understanding. It is even more challenging to serve congregants' needs when mental health in self is not identified, accepted, and addressed, integrating psychological measures with religiosity. The church is a haven for its congregants. Individuals walk through the doors expecting to feel accepted and to experience a supernatural experience and wholeness before returning to their reality—whatever that reality may be. When the church's leadership is not adequately prepared mentally, emotionally, and spiritually, it is difficult to serve congregants the way the Lord calls us to. Effective leadership comes from a place of wholeness. When Jesus heard this, he told them (his followers), "Healthy people do not need a doctor—sick people do. I have come to call not those who think they are righteous, but those who are sinners" (*New Living Translation*, 2015, Mark 2:17).

Leaders are not exempt from this verse. If anything, they are the very first individuals that this verse applies to because they are human and vulnerable to congregants and all the situations they encompass. Knowing that Christianity was founded on the premise that it would be a place of safety, healing, restoration, and redemption to be able to fulfill the Great Commission should motivate leaders within the church to become more aware of the "how" and the "why" relating to their mental health and emotional intelligence. Being equipped and emotionally intelligent allows leaders to effectively shepherd their sheep out of a dark place and into a place of joy. When

coupled with the Word of God and support from spiritual leaders, the science of psychology can effectively allow any individual who truly wants to break through to begin to understand their place within the narrative of God and their calling (Wolters, 2005).

Individuals in distress want to heal their wounds, and others carry scars from their healed wounds (Rudolph & Landman, 2019). Latino leaders and pastors who can accept and understand that "He comforts us in all our troubles so that we can comfort others" (*New Living Translation*, 2 Corinthians 1:4a) can use their healing to help congregants heal. Leading from a place of healing allows the leader or pastor to be in tune with their emotional intelligence and mental health.

Importance of Mental Health

There is always a need for pastors and leaders in the church to become more aware of their mental health because of the great demands and responsibilities that accompany the position (Kansiewicz et. Al., (2021). Everyone is a part of God's creation, sin's destructive power has touched everyone, and everyone can participate in the renewing work of God in Christ and by the Spirit (Wolters, 2005). Changing the conversation for Latino leaders in the church regarding mental health awareness includes improving openness to help-seeking by introducing mental health literacy, training, and benefits associated with being emotionally intelligent to help congregants better during crises.

Shifting the conversation and introducing awareness and literacy regarding mental health will provide leaders and pastors with educational and prevention tools. Mental health awareness and literacy will help leaders and pastors develop cognitive flexibility (Kansiewicz et. Al., (2021). Change is contemporary and causes internal and external factors to build within the workplace and at home among leaders, pastors, and their families (Rudolph & Landman, 2019). It is easy for leaders and pastors within the church to focus on ill-being rather than well-being when there is a lack of knowledge and emotional intelligence.

The science of psychology does not replace the Word of God. Nothing can replace what the Word of God has to offer His children. Every individual is responsible for their relationship with God. Psychology does not stand in place or fulfill the relationship with self only found in Christ. The Science of Psychology collaborates with the Word of God to bring healing and wholeness to those in need, leaders included. "Nothing in all creation is hidden from God. Everything is naked and exposed before His eyes, and He is the one to whom we are accountable" (*New Living Translation*, 2015, Hebrews 4:13). Committing self to a vertical relationship with God

sets the tone for personal, mental, emotional, and spiritual recovery and growth. It is essential to understand that there must be acceptance and forgiveness of self for growth and healing to occur. Practicing acceptance and forgiveness sets the tone for mental health recovery. It equips any individual, including leaders, to be receptive to the work that needs to be done by self to be in a healthy position to lead and serve others.

The State of Mental Health in America (MHA, 2023) reports that over 50 million Americans have mental health problems daily. That is, 21% of America are dealing with a mental health condition. The science of psychology provides tools that collaborate with spiritual tools used to fight for one's mind, heart, and family. Together, psychology and religiosity can help individuals and leaders recover and heal. For example, a leader who is not equipped and suffers from anxiety can pray for peace and calm in the middle of their anxiety attack. However, a trained leader who has addressed their mental health and emotional intelligence conditions can exercise psychological tools such as coping mechanisms and breathing exercises. Those psychological tools, prayer, affirmations, and scripture work together to get them through their anxiety attack without compromising their spirituality. They can also effectively be used to help other congregants through their crises. "Wisdom is more precious than rubies; nothing you desire can compare with Her" (*New Living Translation*, 2015, Proverbs 3:15). Johnson (2010) says, "Transformational psychology affirms with Scripture that psychology as a science is capable of providing prescriptions and wisdom for living."

Problem Statement

Latino church leaders play a vital role in the Hispanic community but often face unique challenges and stressors that can impact their mental health and emotional well-being. This can affect their ability to effectively lead others. Lack of emotional intelligence is a prevalent problem for Latino leaders in the church (Kansiewicz et al., 2022). Factors that are considered detrimental to the emotional deficit experienced by Latino leaders in the church include being aware of their feelings, identifying their weaknesses and limitations, understanding how their past experiences affect their present, lack of forgiveness, and understanding how others experience them (Scazzero, 2015). Due to the lack of emotional intelligence awareness, Latino leaders in the church cannot effectively help during mental health crises. Mental illness has been culturally defined and often perceived as a spiritual problem rather than a health issue among Latino leaders in the church (Caplan, 2019). Latinos who choose culturally accepted resources over mental health literacy pose a

problem in their ability to effectively help during mental health crises (Kutcher, Bagnell, & Wei, 2015). Awareness of mental health literacy and mental healthcare options is pivotal to improving the interaction and engagement that Latino leaders in the church have with congregants while assisting during mental health crises.

Latino leaders in the church who are aware of mental health literacy can help promote anti-stigma interventions. They are challenged amidst surprise, despair, and contradictions when there is no awareness of mental health literacy (Smith, 2020). Latino leaders in the church cannot help others if they cannot first care and help themselves because they may be unable to teach what one does not know (Smith, 2014). There is not enough research presenting data on Latino leaders' use of mental health literacy or the intersection between mental health and emotional intelligence among Latino church leaders. Furthermore, there is a lack of research evaluating the effectiveness of interventions targeted toward enhancing mental health awareness and emotional intelligence among Latino church leaders. Pastor Peter Scazzero wrote a book—*The Emotionally Healthy Leader*—that teaches the importance of emotional intelligence and awareness of mental health literacy and health care options. This book is available to Spanish-speaking only individuals as well. A pilot study on *The Emotionally Healthy Leader* will be conducted to increase mental health awareness and emotional intelligence, and the ability to help congregants during mental health crises.

Purpose of the Study

This study aims to investigate the effectiveness of *The Emotionally Healthy Leader* as an intervention to increase mental health awareness and emotional intelligence in Latino church leaders. It seeks to explore the specific challenges and stressors faced by Latino church leaders that may impact their mental health and emotional well-being and seeks to understand the potential benefits of enhancing emotional intelligence to promote better mental health and emotional well-being among them.

Research Question(s) and Hypotheses

Research Questions

RQ1: Would *The Emotionally Healthy Leader* training significantly increase mental health awareness in the Latino church leader compared to the control group?

RQ2: Would *The Emotionally Healthy Leader* training significantly increase emotional intelligence in the Latino church leader compared to the control group?

RQ3: Would *The Emotionally Healthy Leader* training significantly decrease depression and anxiety in Latino church leaders compared to the control group?

Hypotheses

Hypothesis 1

H_0: *The Emotionally Healthy Leader* training does not significantly increase mental health awareness in the Latino church leader compared to the control group.

H_1: *The Emotionally Healthy Leader* training significantly increases mental health awareness in the Latino church leader compared to the control group.

Hypothesis 2

H_0: *The Emotionally Healthy Leader* training does not significantly increase emotional intelligence in the Latino church leader compared to the control group.

H_1: *The Emotionally Healthy Leader* training significantly increases emotional intelligence in the Latino church leader compared to the control group.

Hypothesis 3a

H_0: *The Emotionally Healthy Leader* training does not significantly decrease depression in the Latino church leader compared to the control group.

H_1: *The Emotionally Healthy Leader* training significantly decreases depression in the Latino church leader compared to the control group.

Hypothesis 3b

H_0: *The Emotionally Healthy Leader* training does not significantly decrease anxiety in the Latino church leader compared to the control group.

H_1: *The Emotionally Healthy Leader* training significantly decreases anxiety in the Latino church leader compared to the control group.

Assumptions and Limitations of the Study

Assumptions

This research assumes that emotional intelligence and mental health awareness are necessary for Latino church leaders to effectively help congregants. It is assumed that *The Emotionally Healthy Leader* is designed to address mental health awareness and emotional intelligence in a culturally appropriate and effective manner for Latino church leaders. This research also assumes that Latino church leaders' cultural background and experiences may influence their emotional intelligence, mental health awareness, and their ability to help congregants.

Study Limitations

This research may face limitations in generalizability as it focuses specifically on Latino church leaders and may limit its generalizability to leaders from other cultural and ethnic backgrounds. Different cultural contexts and religious traditions may influence

the expression and perception of emotional intelligence and mental health issues differently. Therefore, the findings may not be applicable to leaders in non-Latino or non-Christian religious settings.

The sample size of the research may be limited, which can impact the statistical power and generalizability of the findings. A small sample size may not adequately represent the diversity within the population of Latino church leaders, leading to potentially biased or unreliable results.

The research may rely on self-reporting measures for assessing emotional intelligence, which can introduce biases and inaccuracies. Participants may overestimate or underestimate their emotional intelligence levels due to social desirability bias or lack of self-awareness. Additionally, self-report measures may not capture the nuances of emotional intelligence accurately, as they rely on individuals' perceptions of their own abilities rather than objective assessments.

Measurement of the effectiveness of interventions such as *The Emotionally Healthy Leader* intervention may be challenging. Factors outside the scope of the study, such as external support systems or individual differences among leaders, may influence their ability to effectively assist congregants with mental health issues. Without controlling for these external factors, it may be difficult to attribute changes in emotional intelligence or mental health outcomes solely to the intervention.

Lastly, The research may not account for all relevant factors that could influence the effectiveness of Latino church leaders in assisting their congregants with mental health issues. For example, the level of training or years of experience working as a leader in the church may impact their ability to provide support and guidance effectively. Failure to control for these variables could confound the results and limit the validity of the findings.

Theoretical Foundations of the Study

The theoretical foundation for this study is based on the Transformational Leadership Theory (Bass, 1985). This theory focuses on the impact of leaders' emotional intelligence on their ability to help, inspire, and motivate others. This research examines how Latino church leaders' mental health influences their emotional intelligence and capacity to effectively lead and maintain relationships with their congregants. In the Transformational Leadership Theory (Bass, 1985), Transformational leaders inspire and motivate their followers by articulating a compelling vision and encouraging them to go beyond self-interest for the greater good of the organization

or community. Leaders also promote innovation and creativity among their followers by challenging assumptions, encouraging critical thinking, and fostering a culture of learning and growth. Transformational leaders show genuine concern for the needs and development of each follower, providing support, coaching, and mentorship tailored to individual strengths and weaknesses. Transformational leaders often possess charismatic qualities that enable them to connect emotionally with their followers, building trust, loyalty, and commitment.

Martinez et al. (2023) investigate the relationship between mental health and emotional intelligence, specifically among Latino church leaders. It reveals that mental health issues such as stress, anxiety, and depression can negatively impact emotional intelligence competencies, including self-awareness, self-regulation, social awareness, and relationship management, among this population. The Bible emphasizes the importance of self-care and the well-being of individuals. “Don’t you realize that your body is the temple of the Holy Spirit, who lives in you and was given to you by God? You do not belong to yourself, for God bought you with a high price. So, you must honor God with your body” (*New Living Translation*, 2015, 1 Corinthians 6:19-20). This verse references the importance of individuals caring for their mental and emotional well-being.

Ramirez et al. (2022) examine the role of mental health awareness in shaping emotional intelligence among Latino church leaders. It suggests that leaders who are more aware of their mental health status and actively engage in strategies to maintain their well-being tend to exhibit higher levels of emotional intelligence, which in turn positively influences their leadership effectiveness and the well-being of their congregations. “Getting wisdom is the wisest thing you can do! And whatever else you do, develop good judgment” (*New Living Translation,* 2015, Proverbs 4:7). It is important for Latino church leaders to seek wisdom and develop their emotional intelligence so they can better serve their congregants. “Since God chose you to be the holy people he loves, you must clothe yourselves with tenderhearted mercy, kindness, humility, gentleness, and patience” (*New Living Translation*, 2015, Colossians 3:12).

Compassion is a skill and empathy an attribute of compassion that Latino church leaders should develop. Developing emotional intelligence allows church leaders to better empathize with and understand the emotions and struggles of their congregants. “Share each other’s burdens, and in this way obey the Law of Christ,” (*New Living Translation*, 2015, Galatians 6:2). By being emotionally intelligent, Latino church leaders can help foster an environment that supports mental health and emotional well-being, providing a safe

space for congregants to feel welcomes to seek help and support. These biblical principles can help Latino church leaders understand the importance of mental health and emotional intelligence within their faith and leadership roles.

Understanding the distinctions of transformational leadership theory and its application within the context of Latino church leadership, coupled with recent research on the effects of mental health on emotional intelligence in this demographic, organizations can better support their leaders and foster environments conducive to both personal and collective well-being.

Definition of Terms

The following is a list of definitions of terms that are used in this study.

Awareness – is the knowledge or perception of a situation or fact (*Oxford English Dictionary*, 2019).

Emotional Intelligence – is the capacity to be aware of, control, and express one's emotions and to handle interpersonal relationships judiciously and empathetically (*Oxford English Dictionary*, 2019).

Leader – is the person who leads or commands a group, organization, or county (*Oxford English Dictionary*, 2019).

Mental Health – is a person's condition regarding their psychological and emotional well-being (*Oxford English Dictionary*, 2019).

Significance of the Study

This research will help bridge the gap in coping patterns and help-seeking among leaders and pastors within the church. It will also provide background information on the different perspectives leadership within the church has regarding self, emotional intelligence, and the ability to help others. This study will further the limited research on leadership within the church and the relationship between emotional intelligence, awareness of mental health literacy and healthcare options, and the ability to help during a

mental health crisis. This research will help identify whether interventions for leadership play a significant role in their ability to acknowledge their emotional intelligence.

The significance of this study is multifaceted. This research is important because it will provide insight that will allow for cultural relevance. Understanding the impact of mental health on emotional intelligence, specifically, as it relates to Latino church leaders, acknowledges that there is a unique cultural context in which they operate. This research will explore the relationship between mental health and emotional intelligence in Latino church leaders that can contribute to raising awareness about mental health issues within the church. The outcome of this research can help reduce the stigma surrounding mental health struggles and promote mental health and well-being among Latino church leaders.

This research aims to investigate how mental health influences emotional intelligence in Latino church leaders, which can enhance their effectiveness. Findings from this research can help identify the development of needed interventions and support systems for Latino church leaders to benefit from. This will help bring awareness to services that can be created to help improve emotional intelligence and provide resources tailored to the needs of Latino church leaders. Studying the effect of mental health on emotional intelligence in Latino church leaders can contribute to a comprehensive understanding of the factors that influence their well-being and leadership abilities. This research has the potential to inform on interventions, reduce stigma, and promote mental health awareness within the church.

Summary

The goal of integrating and applying psychology and Christianity is to work together in God's original design for everyone. “And you will know the truth, and the truth will set you free” (*New Living Translation*, 2015, John 8:32). “Jesus told him, ‘I am the way, the truth, and the life,” (*New Living Translation*, 2015, John 14:6). God is calling us to break out of the artificial ideologies that there is no place for psychology in the church. It is time to accept that, instead of fighting against the current, if leaders use psychology and what they know to be true in Christianity, the church can be an unstoppable force bringing hope, healing, and awareness of the gift of salvation to all who enter. *“*Wise choices will watch over you. Understanding will keep you safe*”* (*New Living Translation*, 2015, Proverbs 2:11). There are ways to target interventions for leaders and pastors to help them improve their emotional intelligence and

availability of mental health resources (Kansiewicz et al., 2021). This research hopes to bring awareness of the emotional intelligence condition of self while equipping each participant with the necessary tools to be aware and better equipped to help others. Research shows that mental health plays a role in emotional intelligence.

CHAPTER 2: LITERATURE REVIEW

Overview

The relationship between religion and overall mental health is complex (Martinez De Pisón, 2022). Pastors and leaders are part of humanity and are not exempt from struggles with emotional intelligence. Latino leaders and pastors within the church have emotional baggage to work through. Working through their emotional baggage is fundamental to achieving mental and emotional healing to help congregants during crises effectively (Rudolph & Landman, 2019). Hispanic mental health care utilization is half that of non-Hispanic whites (Caplan, 2019). Research has identified that cultural and religious values significantly affect mental health care disparities (Gonzáles et al., 2010). Because congregants with mental illnesses often seek out clergy, it is essential to understand their perspectives about mental and emotional problems and identify the individual characteristics that influence their attitudes (Hays & Payne, 2020).

Leadership in the church needs to get along with people; this is hard to accomplish if emotional intelligence and relational skills go unnoticed (White & Kimmons, 2019). Emotional intelligence can enhance leadership, teamwork, and personal resilience (Pegram, 2018). Leadership within the church plays an integral part in the community it serves. The need to fulfill many duties within the church can lead to immense psychosocial stress needing to be accepted (Webb & Chase, 2018). Finite human realities are grounded in God's creative weakness, inescapable presence, infinite grace and glory, justice, and unconditional love (Smith, 2020). For leadership in the church to experience a breakthrough from dishonesty, pretense, and binding fears takes trust, imagination, power, courage, and wisdom along with humor and a sense of mature self-other forgiveness (a final form of love) when facing certain undeniable human realities (Smith, 2020). Spiritual development strengthens, reinforces, and helps in the development of emotional intelligence among clergy (Andrei, 2023). A lack of emotional intelligence leads not only to spiritual death but has the potential to lead to physical harm, not limited to suicide (Ming, 2022).

Description of Research Strategy

The following databases were used to search the peer-reviewed literature for the previous five years: ProQuest, Psychology & Behavioral Sciences Collection (EBSCO), PsycINFO, PsycARTICLES, and APA PsycNET. The following search terms were used:

church, clergy, coping, emotional intelligence, forgiveness, Latino leaders, mechanisms, mental health, mental health awareness, mental health literacy, and *spirituality*. The search was limited to peer-reviewed and original research articles only. Biblical research was conducted using the glossary in the Bible followed by the reading of Scripture surrounding identified relevant bible verses. The Jerry Falwell Library Database was also used to find relevant biblical research pertaining to emotional intelligence, leadership, mental health, and spirituality.

Review of Literature

Emotional Intelligence

Clergy are integral to the operation of faith-based organizations (FBOs), (Webb & Chase, 2018). In their study, Webb and Chase (2018) wanted to expand the research and literature regarding clergy and their emotional intelligence. Their aim was to examine whether there was an association between occupational distress, physical and mental health, physical activity, and sedentary behavior (Webb & Chase, 2018). Their findings were consistent with their hypothesis that occupational distress was associated with a lack of emotional intelligence and mental health conditions. Occupational distress was found to negatively influence clergy (Webb & Chase, 2018). Leaders in the church need the ability to understand and relate to other people as well as operate with healthy self-awareness to be faithful and effective in ministry (White & Kimmons, 2019). Emotional intelligence can assist clergy in establishing rapport, trust, and navigating complicated interpersonal dynamics among their congregations. Leaders in the church need to be able to get along with other people and this requires emotional intelligence (White & Kimmons, 2019).

Research suggests that Theological schools and Christian higher education have opportunities within the curriculum to develop emotional intelligence among the clergy (White & Kimmons, 2019). Emotional intelligence is the core of effective leaders (Waglay et al., 2020). They aimed to investigate the role emotional intelligence plays in effective leadership. Emotional intelligence is a key ingredient in the formation of high-quality leader-member exchange (LMX) relationships (Waglay et al., 2020). Their findings established multi-relationships with leadership being a significant predictor for leader-member exchanges and emotional intelligence. A positive relationship was found between emotional intelligence and leader-member exchanges. Emotional intelligence is key to building relationships and effective leadership (Waglay et al., 2020). A lack of emotional intelligence leads not only to spiritual death, but has

the potential to lead to physical harm, not limited to suicide (Ming, 2022). A leadership crisis occurs because of a lack of trust in leaders who are involved in too many conflicts (Ming, 2022). Constructive reflection is needed within leaders for the development of an effective church. A lack of emotional intelligence can lead to failed leadership within the church (Ming, 2022).

The focus of pastors and leaders is primarily on their congregants and the communities they serve; and they often neglect their own well-being (Rudolph & Landman, 2019). Research revealed that emotional intelligence is an important factor in leading effectively in their calling (Rudolph & Landman, 2019). Leaders are unable to help or care for others if they first do not help or care for themselves (Smith, 2020). Religious and mental health functions and forgiveness remain central to the care of emotional intelligence in leaders within the church (Smith, 2020). Closed-mindedness can lead to fear, confusion, anger, and disillusion, all of which affect the emotional intelligence of leaders and their ability to effectively lead congregants. Clergy who are unable to cope with challenges in their own lives may be ineffective in helping congregants cope with their stress (Terry & Cunningham, 2019). A culture based on love, appreciation, and self-care for both self and others establishes a good framework for increased emotional intelligence and effective leadership (Baykal & Zehir, 2018). The research identified that there is a great significance in both the relationship between emotional intelligence and spiritual leadership and emotional intelligence and effective leadership performance. Greater emotional intelligence has been shown to be associated with greater positive attitudes toward God, lower anger toward God, and greater forgiveness of self and towards others (Jankowski et al., 2018). Religious leaders who exhibit spirituality and higher levels of low concern for status are associated with greater emotional intelligence, positive mental health, and lower levels of mental health problems (Jankowski et al., 2018).

Spiritual intelligence is defined as being compassionate, exhibiting wisdom, and being peaceful (Andrei, 2023). A leader who submits the characteristics of spiritual intelligence to human psychology and morality limits their potential emotional intelligence growth and effectiveness to be a relational leader. Andrei (2023) reviewed literature pertaining to spiritual and emotional intelligence to provide an overview to help improve leader-congregant relationships within the church. The review aimed to focus on the importance of religious education, emotional intelligence, and spiritual intelligence to sharpen leadership skills at any level. Emotional and spiritual intelligence promote characteristics that help leaders effectively perform their duties and helps improve relationships with others

(Andrei, 2023). Leaders in the church have high demands placed on them, which puts them at risk for mental health problems and a lack of emotional intelligence if they are not aware of their spiritual and emotional intelligence condition (Biru et al., 2022). Clergy who experienced elevated anxiety and depression symptoms were not fully aware of their emotional intelligence and saw a decline in their spiritual intelligence as well (Biru et al., 2022). Research provides data on the difference in mental health symptoms displayed by those clergy who were aware of their mental health and sought professional help compared to those who lacked awareness and did not seek help. Being aware of one's emotional intelligence and mental health condition can lead to clergy receiving the help they need which can potentially help them flourish as individuals and help them serve congregants more effectively (Biru et al., 2022).

Clergy are often sought out by individuals dealing with mental health illnesses; therefore, it is important to understand the mindset behind clergy's perspective on self-awareness and accepting professional mental health support or at least being aware of the resources available (Hays & Payne, 2020). A clergy's personal struggles with mental health issues and emotional intelligence awareness without receiving proper help will likely shape their attitudes and responses to congregants seeking help, making their leadership ineffective and biased, which is everything contrary to what effective leadership *should* look like (Hays & Payne, 2020). It is important for leaders to be aware of their emotional intelligence because it can lead to leadership enhancement, mental health awareness, resilience, and relational effectiveness (Pegram, 2018). Research regarding clergy and emotional intelligence is sparse. A ProQuest search revealed that it is likely for emotional intelligence to be studied in other professions than it is to be studied specifically as it relates to Christian ministry (Pegram, 2018). These results call for proper research to be conducted that can identify the actual levels of emotional intelligence leaders are currently struggling with to facilitate frameworks and theories to be implemented that can help raise emotional intelligence awareness in leaders that will set the tone for mental health and spiritual awareness.

Mental Health Awareness

The relationship between spirituality and overall mental health is complex (Martinez de Pisón, 2022). Any mental disorder that affects the overall well-functioning of a person negatively impacts how the person deals with God and others (Martinez de Pisón, 2022). Church leaders confront specific problems that might have an influence on their mental health, such as high levels of responsibility, emotional pressures, and the desire to address the needs of their congregations. Prioritizing mental health is critical for

church leaders who want to preserve their own well-being while they also actively support others. This may entail getting help, practicing self-care, and accessing mental health services. Spirituality can contribute with individuals' efforts towards being aware of their mental health, accepting their mental health, seeking help, and becoming more knowledgeable regarding mental health (Martinez de Pisón, 2022). The World Health Organization (WHO) defines health as a state of complete physical, mental, and social well-being (WHO, 2000). Major areas of concern that clergy deal with are marital or family satisfaction, physical health, problem dealing with relationships in the church, and emotional and mental health (Poon, 2019). Mental health is an important part of good clergy leadership because leaders must be able to assist, guide, and comprehend persons in their communities while also prioritizing their own mental health.

Poon (2019) establishes that seminary school does *not* prepare clergy to adjust and interact with the real world. Research shows that not much attention has been given to clergy and their mental health. Clergy should remind themselves to be present and aware of their mental health condition as well as have regular physical, ministry, and mental health checkups (Poon, 2019). Clergy have a difficult time providing effective counseling for issues within the church because they personally need counseling and assistance. Leaders in the faith who have interpersonal relationships with congregants might confront stressful situations that may challenge their spiritual and mental health along with their quality of life (Currier et al., 2019). Individuals who struggle with their mental health including clergy face a double problem where they are not only dealing with their symptoms, but they also must deal with the burden associated with mental illness stigma (Mayer et al., 2021). Being aware of any mental health challenges and having the literacy to help through a mental health challenge can help individuals receive support and be more effective in their roles. Research shows that being aware, having mental health literacy, and seeking help is linked with a better quality of life and recovery (Mayer et al., 2021).

The relationship between psychology and the church has a tumultuous history (Hodge et al., 2020). Despite the history that lies between psychology and the church, they both share several goals, such as alleviating human suffering, addressing social problems, and promoting human flourishing, none of which is possible if clergies are not aware of their own mental health and lack the literacy to help others (Hodge et al., 2020). Louca (2021) shares that it is important to have a holistic approach that acknowledges religion and faith's positive and negative effects on mental health. There is a distinction between feeling supported by others and sharing one’s problems.

This requires active effort (Jacob et al., 2022). Clergy become more available to congregants when they can share from a place of experience and healing (Hook et al., 2020). Clergy provide not only positive social support but also emotional support and cannot do so effectively if they are not aware of their current mental state (Jacob et al., 2022). Faith-based organizations (FBOs) play a major role in Latino communities and are often associated with support, hope, and acceptance (Nogueira & Schmidt, 2022). Mental health literacy is important among clergy because it refers to the knowledge that benefits one's mental health, including prevention, recognition, effective self-help strategies, and first-aid skills to help others (Nogueira & Schmidt, 2022). Mental health literacy also helps clergy obtain and maintain positive mental health—knowing when and where to seek help and developing competencies to improve one's mental health care and self-management capabilities (Nogueira & Schmidt, 2022). Clergy involvement should be a fundamental piece of mental health literacy interventions to help improve treatment engagement among congregants (Nogueria & Schmidt, 2022).

Research shows there is a lack of documented results on faith-based mental health literacy use by clergy tailored to Latinos. It is proven that religion and spirituality have the capability to foster a sense of belonging and connectedness with others which is needed by clergy to maintain healthy interpersonal relationships within their congregations (Caplan, 2019). On the contrary, there is also evidence that reports that individuals suffering from mental illnesses are not always accepted in a religious setting and can sometimes be misunderstood and looked upon as experiencing a lack of faith which can lead clergies to not want to accept or share their struggles to avoid feeling rejected or looked down upon (Caplan, 2019). Clergies and individuals who receive spiritual support for their condition and find spiritual practices helpful are more receptive to integrating their spirituality with wellness programs (Yamada et al., 2020). This is why it is important for even clergy to be aware of their mental health and be able to find support in their spirituality to be receptive to serving others from a place of healing and life experiences. Lutz and Eagle (2019) share that there has been a significant positive association among clergy dealing with depression who feel isolated and their inability to effectively lead congregants. There is an increased need for tailored interventions and support systems to affectively address church leaders' mental health needs (Kansiewicz et al., 2022).

Mental Health

Religiosity and mental health also have a bidirectional influence on each other (Cook, 2020). Spiritual and mental well-being are both marked by a willingness or ability to be attentive to things that matter (Cook, 2020). Research shows that individuals who are more committed to their religious faith and spiritual convictions are happier, healthier, and have more coping resources at their disposal than those for whom religion and spirituality are less important (Sharma & Singh, 2019). Mediational analysis revealed that having a grateful perspective mediated the relationship between religiosity and well-being, allowing clergy to forgive themselves and be effective in their leadership (Sharma & Singh, 2019). The research established that religiosity combined with interventions and support systems can positively promote well-being among the clergy. Clergy might be prone to not seek help despite having support systems and interventions available to them due to the mental health stigmas surrounding the culture (Campbell, 2021). Research shows that clergy are influential in their positions, and they feel the pressure of caring more about what congregants might think of them or how they might see them if they came forward with a mental health concern of their own to prioritize their own health. Stigma has been proven to be a major barrier to influencing whether mental health is addressed by clergies for clergies (Campbell, 2021).

Corrigan (2004) shares that stigma is one of many reasons clergy choose to avoid mental health conversations. Ryan (2018) shares over the past few years, the church has shown a significant interest in the need for mental health awareness and resources to help not only their clergy increase their emotional intelligence but also to help them be more aware of their mental health to become more effective in leading congregants. Koenig et al., (2021) conducted a meta-analysis that discovered associations between mental health, stigma, and religiosity and highlighted the need for continuous research to continue studying the relationships between clergy, mental health, stigma, and effective leadership. Positive religious coping demonstrates positive associations with mental health, while negative religious coping tends to have the reverse effect (Dein, 2020). Clergy who can accept their mental health and are aware of their lack of emotional intelligence become vulnerable and receptive to healing (Dein, 2020). Research shows it is important for clergy to be aware of their emotional intelligence and mental health because even though they may not personally counsel their congregants, clergy are often on the “front lines” of mental health treatment (Hodge et al., 2020).

Latino church leaders who can prioritize their mental health and well-being are more likely to increase their emotional intelligence. It is important for clergy to prioritize self-care and seek support for their mental health needs to better serve their congregants. When clergy struggle with mental health issues, it can affect their emotional well-being and ability to effectively lead and interact with others (Venter & Hermans, 2020). A full 20.78 % of adults struggle with any mental health illness (AMI; MHA, 2023). For clergy to be sensitive to helping others and their traumas experienced, they must be aware of self and mental health resources available to help others, which is essential in the helping process as clergy (Hill & Yancey, 2022). Research emphasizes the importance of clergys' mental well-being and the need for churches to be able to provide support and resources to promote emotional intelligence within the church community (Abbey & George, 2019). Village and Francis (2023) introduced the Francis Psychological Type and Emotional Temperament Scales (FPTETS) in a research study that highlights the importance of clergy being aware of their emotional intelligence and mental health to recognize, understand, and manage their own emotions as well as empathize with others.

Francis et al., (2018) share that a clergy's ability to communicate with others, engage in conflict resolution, and be aware of their overall mental well-being depends on their ability to be aware of their emotional intelligence. Costello et al., (2020) posit that mental health first aid can increase emotional intelligence and enhance mental health awareness by encouraging clergy to recognize and respond to their own mental health needs and those of their congregants. Holleman (2023) recognizes that occupational distress, such as burnout or work-related stress, plays a significant role in the impact of mental health on emotional intelligence in clergy. When clergy can perceive mental health services positively within the church, it indicates that there is recognition and acceptance of the importance of addressing mental health issues within self as much as with congregants (Burse et al., 2021). It is important to highlight that a clergy's perception of mental health services play a critical role in fostering emotional intelligence among Latino church leaders. Positive perceptions can lead to increased awareness, acceptance, and utilization of mental health services by clergy, which ultimately promotes emotional well-being and enhances emotional intelligence (Burse et al., 2021).

The Emotionally Healthy Leader Intervention

The Emotionally Healthy Leader emphasizes that for any leader to be effective, they must prioritize their emotional and mental health (Scazzero, 2015). It is designed to equip leaders, particularly in religious settings such as churches, with the skills and tools

necessary to foster emotional health and well-being among themselves and their communities. It argues that leaders focus solely on their professional skills and neglect their emotional intelligence and mental health, which ultimately hinders their ability to lead effectively and cultivate healthy relationships. Scazzero (2015) emphasizes the importance of self-awareness, self-regulation, self-care, empathy, and effective interpersonal relationships, all of which are key components of emotional intelligence.

It provides practical strategies and tools for leaders to develop and maintain emotional health, such as setting boundaries, practicing mindfulness, managing stress, and cultivating healthy relationships. *The Emotionally Healthy Leader* provides participants with the necessary tools to recognize and understand their own emotions, strengths, weaknesses, and triggers, which is foundational to developing emotional intelligence. This intervention teaches techniques for managing and regulating one's emotions, including stress management, impulse control, and coping strategies. It encourages leaders to cultivate empathy towards others, understanding their perspectives and emotions, which fosters stronger relationships and community support. Through this intervention, participants can learn communication skills, conflict resolution techniques, and ways to build healthy, supportive relationships within their leadership roles and communities.

The Emotionally Healthy Leader book also addresses common challenges and issues that leaders face, such as burnout, work-life balance, and managing conflicts. It offers guidance on navigating these challenges while maintaining emotional well-being and fostering a positive work environment. Scazzero's (2015) research for the book was influenced by his own journey of transformation and growth as a leader. In his research, Scazzero extensively studied the connection between emotional health and effective leadership. He explored topics such as self-awareness, self–regulation, self-care, managing emotions, empathy, and interpersonal relationships. He also delved into the impact of emotional health on decision-making, conflict resolution, and team dynamics. Scazzero (2015) drew from scientific research, psychological principles, and biblical teachings to develop his ideas and strategies for becoming an emotionally healthy leader. He also incorporated insights from other leadership experts, psychologists, and spiritual leaders to provide a comprehensive and practical guide for leaders seeking emotional health.

Rodriguez et al. (2021) evaluates the effectiveness of The Emotionally Healthy Leader program in enhancing emotional intelligence and mental health outcomes among Latino church leaders. Results indicate significant improvements in participants'

emotional intelligence competencies, including self-awareness, self-regulation, empathy, and relationship management. Additionally, participants reported reduced levels of stress, anxiety, and depression, suggesting positive effects on mental health. Garcia et al. (2022) investigates the role of *The Emotionally Healthy Leader* program in cultivating emotional intelligence among Latino church leaders. Findings reveal that program participants demonstrated increased levels of emotional intelligence, particularly in areas related to self-awareness, self-regulation, and interpersonal relationships. These improvements were associated with enhanced leadership effectiveness and greater support for congregants' mental health needs. Diaz et al. (2023) assesses the effectiveness of *The Emotionally Healthy Leader* program in addressing mental health challenges faced by Latino church leaders. Results indicate that program participants reported improved emotional well-being, decreased levels of burnout, and increased capacity to support congregants' mental health needs. The program's emphasis on self-care, boundary-setting, and interpersonal skills contributed to these positive outcomes.

These studies highlight the significance of programs like *The Emotionally Healthy Leader* in enhancing emotional intelligence and mental health outcomes among Latino church leaders, ultimately benefiting both leaders and their congregations.

Biblical Foundations of the Study

Christ created all things in Him, through Him, and for a relationship with Him. The Science of Psychology is a part of God's design for the church to receive help and help others. It also serves as a platform to help individuals unite and sharpen each other. "So, we have not stopped praying for you since we first heard about you. We ask God to give you complete knowledge of his will and to give you spiritual wisdom and understanding. Then the way you live will always honor and please the Lord, and your lives will produce every kind of good fruit. You will grow as you learn to know God better and better." (*New Living Translation*, 2015, Colossians 1:9-10). The call of Wisdom appeals to all creation to pay attention and learn from Her, for Her insight and understanding are genuinely available to them if they need Her (Wolters, 2005).

It is difficult to maintain the state of one's heart aligned with living a life of wisdom and understanding. It is even more challenging to serve congregants' needs when mental health in self is not identified, accepted, and addressed, integrating psychological measures with religiosity. The church is a haven for its congregants. Individuals walk through the doors expecting to feel accepted and

experience a supernatural experience and wholeness before returning to their reality, whatever it may be. When the church's leadership is not adequately prepared mentally, emotionally, and spiritually, it is hard to serve congregants the way the Lord calls us to. Effective leadership comes from a place of wholeness. Dealing with mental health conditions causes complications in life. When Jesus heard this, he told them, "Healthy people do not need a doctor—sick people do. I have come to call not those who think they are righteous, but those who are sinners." (*New Living Translation*, 2015, Mark 2:17).

Individuals in distress want to heal their wounds, and others carry scars from their healed wounds (Rudolph & Landman, 2019). Latino leaders and pastors who can accept and understand that "He comforts us in all our troubles so that we can comfort others." (*New Living Translation*, 2 Corinthians 1:4a) can use their healing to help congregants heal. Leading from a place of healing allows the leader or pastor to be in tune with their emotional intelligence and mental health.

The science of psychology does not replace the Word of God. Nothing can replace what the Word of God has to offer his children. Every individual is responsible for their relationship with God. Psychology does not stand in place or fulfill the relationship with self only found in Christ; instead, it collaborates with the Word of God to bring healing and wholeness to those in need, leaders included. "Nothing in all creation is hidden from God. Everything is naked and exposed before his eyes, and he is the one to whom we are accountable." (*New Living Translation*, 2015, Hebrews 4:13). Committing self to a vertical relationship with God sets the tone for personal, mental, emotional, and spiritual recovery and growth.

It is essential to understand that there must be acceptance and forgiveness of self for growth and healing to occur. Practicing acceptance and forgiveness sets the tone for mental health recovery. It equips any individual, including leaders, to be receptive to the work that needs to be done by self to be in a healthy position to lead and serve others. "Wisdom is more precious than rubies; nothing you desire can compare with her." (*New Living Translation*, 2015, Proverbs 3:15). Johnson (2010) says, "Transformational psychology affirms with Scripture that psychology as a science is capable of providing prescriptions and wisdom for living."

Summary

The mental health of Latino church leaders can significantly impact their emotional intelligence. Latino church leaders face unique challenges and stressors in their roles, which can contribute to mental health issues such as depression, anxiety, and burnout if

not acknowledged, accepted, and dealt with can interfere with effective leadership. Romans 12:2 (*New Living Translation*, 2015) encourages renewing the mind, emphasizing the importance of seeking transformation and healing. Poor mental health can impair key components of emotional intelligence, including self-awareness, self-regulation, and social skills. Through scripture, clergy can find for themselves and offer others solace, encouragement, and wisdom on how to deal with mental health. Proverbs 14:30 (*New Living Translation*, 2015) highlights the connection between a peaceful heart and good emotional health, reminding leaders to prioritize their well-being. Meanwhile, high emotional intelligence can serve as a protective factor against mental health issues. Latino church leaders do not have to carry their mental health struggles alone, as Psalm 55:22 (*New Living Translation*, 2015) encourages them to cast all burdens on the Lord.

Promoting mental health and emotional intelligence in Latino church leaders through biblical integration involves creating a supportive environment that encourages exploration of scripture for mental health guidance. Latino church leaders can better understand their mental health challenges and find strength and resilience in their faith through studying and applying scripture. Biblical integration can support self-awareness, self-regulation, empathy, and social skills, which are key components of emotional intelligence. It provides a framework for seeking guidance, practicing self-care, and fostering healthy relationships. The integration of scripture with the science of psychology fosters a greater alignment between faith and mental health, promoting overall well-being, and more effective leadership.

CHAPTER 3: RESEARCH METHOD

Overview

The purpose of this intervention study was to examine the impact of *The Emotionally Healthy Leader* on the emotional intelligence and mental health of Latino church leaders and explore the relationship between mental health and emotional intelligence. Literature supports that a lack of mental health awareness and poor emotional intelligence can lead to ineffective leadership and poor well-being of individuals. However, further research is needed to know whether interventions can significantly increase mental health awareness and emotional intelligence in Latino church leaders to benefit their well-being and assist their congregants in achieving higher well-being.

Descriptive statistics were calculated for mental health and emotional intelligence scores before and after *The Emotionally Healthy Leader*. This included measures such as the mean, the standard deviation, minimum, maximum, and frequency distributions. An independent samples t-test was performed to compare the mean scores of mental health and emotional intelligence before and after *The Emotionally Healthy Leader*. This analysis determined if there was statistically significant differences in the variables following participation in *The Emotionally Healthy Leader*. A Multivariate Analysis of Variance (MANOVA) was conducted to examine the potential differences in the changes in mental health and emotional intelligence scores based on time. This analysis identifies any significant variations in the intervention's effects across different subgroups.

Research Questions and Hypotheses

Research Questions

RQ1: Would *The Emotionally Healthy Leader* training significantly increase mental health awareness in the Latino church leader compared to the control group?

RQ2: Would *The Emotionally Healthy Leader* training significantly increase emotional intelligence in the Latino church leader compared to the control group?

RQ3: Would *The Emotionally Healthy Leader* training significantly decrease depression and anxiety in Latino church leaders compared to the control group?

Hypotheses

Hypothesis 1

H_0: *The Emotionally Healthy Leader* training does not significantly increase mental health awareness in the Latino church leader compared to the control group.

H_1: *The Emotionally Healthy Leader* training significantly increases mental health awareness in the Latino church leader compared to the control group.

Hypothesis 2

H_0: *The Emotionally Healthy Leader* training does not significantly increase emotional intelligence in the Latino church leader compared to the control group.

H_1: *The Emotionally Healthy Leader* training significantly increases emotional intelligence in the Latino church leader compared to the control group.

Hypothesis 3a

H_0: *The Emotionally Healthy Leader* training does not significantly decrease depression in the Latino church leader compared to the control group.

H_1: *The Emotionally Healthy Leader* training significantly decreases depression in the Latino church leader compared to the control group.

Hypothesis 3b

H_0: *The Emotionally Healthy Leader* training does not significantly decrease anxiety in the Latino church leader compared to the control group.

H_1: *The Emotionally Healthy Leader* training significantly decreases anxiety in the Latino church leader compared to the control group.

Research Design

This experimental study used a pre-post design, assessing participants' mental health and emotional intelligence before and after the intervention. A randomized, controlled trial (RCT) design was used, where participants were randomly assigned to either an intervention group (receiving *The Emotionally Healthy Leader*) or a control group with no intervention. The use of quantitative methods allowed for the collection of numerical data, enabling statistical analysis and the identification of patterns and correlations. This approach provided a measurable understanding of the interaction between variables.

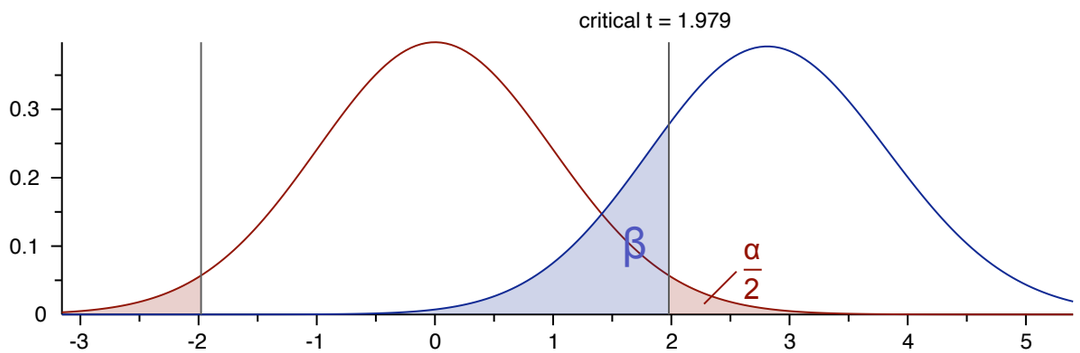
Participants

This study's participants are Latino church leaders within the Christian/Pentecostal denomination. These leaders and pastors were recruited from within the United States. They were 18 years of age or older. This study includes male and female participants. Leaders and pastors participating have varying levels of education, ranging from high school diplomas to advanced degrees. They have diverse levels of experience in leadership roles within their churches, ranging from a minimum of three months to those with several years of experience. Participants came from different socioeconomic backgrounds, representing a range of income levels and occupations. Participants were recruited from various regions or locations to ensure a broad representation of Latino church leaders. Participants expressed a genuine interest in improving their mental health awareness and emotional intelligence, as this enhanced their commitment to *The Emotionally Healthy Leader*. All participants were willing to engage in self-reflection and be open to self-reflection and self-improvement, as *The Emotionally Healthy Leader* requires introspection and the willingness to challenge existing beliefs and practices. Participants had the time and flexibility to participate within their randomly assigned group and completed the necessary assessments and tasks. Participants provided informed consent to indicate their willingness to participate in this study and adhere to its protocols and requirements. Based on the power of analysis, a t-test for Means: Difference between two independent means (two groups) with a medium effect size of 0.05, an alpha of 0.5, and a power of .80, 128 participants were needed to run this intervention study as shown in Figure 1. Based on the power of analysis, a t-test for Means: Difference between two independent means (two

groups) with a large effect size of 0.8, an alpha of 0.5, and a power of .80, 52 participants were needed to run this intervention study as shown in Figure 2. A minimum of 52 participants were needed to complete this experimental study.

Figure 1

*G*Power Sample Size Calculations*

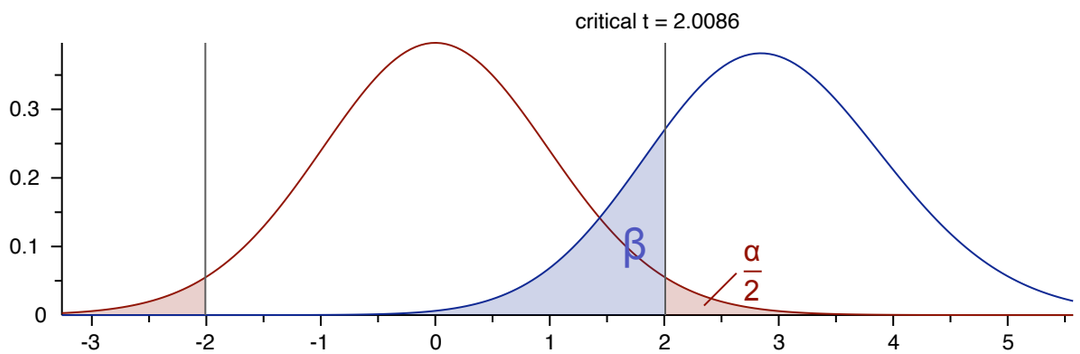


t tests - Means: Difference between two independent means (two groups)

Analysis:	A priori: Compute the required sample size		
Input:	Tail(s)	=	Two
	Effect size d	=	0.5
	α err prob	=	0.05
	Power (1-β err prob)	=	0.8
	Allocation ratio N2/N1	=	1
Output:	Non-centrality parameter δ	=	2.8284271
	Critical t	=	1.9789706
	Df	=	126
	Sample size group 1	=	64
	Sample size group 2	=	64
	Total sample size	=	128
	Actual power	=	0.8014596

Figure 2

*Large Medium G*Power Sample Size Collections*



t tests - Means: Difference between two independent means (two groups)

Analysis:	A priori: Compute required sample size		
Input:	Tail(s)	=	Two
	Effect size d	=	0.8
	α err prob	=	0.05
	Power (1-β err prob)	=	0.8
	Allocation ratio N2/N1	=	1
Output:	Non-centrality parameter δ	=	2.8844410
	Critical t	=	2.0085591
	Df	=	50
	Sample size group 1	=	26
	Sample size group 2	=	26
	Total sample size	=	52
	Actual power	=	0.8074866

Inclusion/Exclusion Criteria

Inclusion criteria included being a church leader or pastor of Latino descent, actively serving in a leadership role within a church community for a minimum of three (3) months, being willing to engage in mental health capacitation and new leadership strategies and self-identifying as spiritual. Participants were 18 years of age or older. In order to participate, they were English-speaking or Bilingual. Exclusion criteria include participants with severe cognitive impairments that would hinder their ability to understand and engage in *The Emotionally Healthy Leader* may be excluded.

Recruitment

Participants were recruited from Latino Christian/Pentecostal denomination churches. Recruitment Flyer (see Appendix A: Recruitment Flyer) was shared on social media and other platforms. Recruitment Letter (see Appendix B: Recruitment Letter) was shared with Latino churches for participation.

Study Procedures

Potential participants within the Latino church community who were actively serving in leadership roles are identified. This is done through personal connections, referrals from other church leaders, recruitment via social media flyers, or contacting local church organizations. All interested participants were contacted individually to introduce the study and explain its purpose. The importance of their participation in contributing to research on mental health and emotional intelligence within the Latino church community is emphasized. Detailed information about this study—including its objectives, procedures, and expected time commitment—was shared with all participants. Participants were provided with informational materials, such as *The Emotionally Healthy Leader*, to ensure clarity and understanding. Prior to participation, participants understood the nature of this study, potential risks, benefits, and their rights as participants. Coordination and flexibility were offered to all participants in terms of timing and allowing them to choose a convenient time for pre/post-data collection. All participants who met the requirements were given a consent form only after they understood the entirety of their participation in this research study and had to complete the following in one sitting: Controlled Variables Questionnaire, PHQ-9, GAD-7, and the Self-reporting Emotional Intelligence Scale. Once all questionnaires and assessments were completed, participants were randomly assigned to either the intervention or control groups.

Intervention

Participants in the Intervention group read *The Emotionally Healthy Leader* and answered the questions provided in *The Emotionally Healthy Leader* throughout the chapter weekly, which were submitted to phdresearchparticipants@gmail.com on the assigned day every week. The intervention group completed the Open-Ended questions upon completion of the Intervention and again,

30 days following the completion of the intervention. The intervention group was also responsible for completing the initial questionnaires again once the intervention was completed. The control group was only responsible for completing the initial questionnaires before the Intervention began and again once the Intervention group had completed its intervention. The control group was not required to do anything while the Intervention group was participating.

Once *The Emotionally Healthy Leader* study was completed, the questions were answered by the designated group, and all the assessments had been completed, the data was reviewed, organized, and analyzed to provide results comparing group differences between the group who participated in *The Emotionally Healthy Leader* and the group who did not. All participants not assigned to the intervention group could request a copy of the intervention by emailing phdresearchparticipants@gmail.com. One will be provided to them once the study is completed.

Instrumentation and Measurement

Controlled Variables Questionnaire

The controlled variable questionnaire—as seen in Appendix C—was used to collect data on participants to guarantee that the participants met the inclusion criteria for the study and was created for this research study by the researcher. The questionnaire collected data on each participant's age (at least 18 years old), gender, ethnicity/cultural background, marital status, education level, and years of experience as a church leader and was organized into categories for participants to select (e.g., male/female, Mexican, Puerto Rican, Cuban, Single/Married, Divorced/Widowed, High School Diploma/Associate/Bachelor's Degree/Master's Degree/Doctorate, etc.,). The participant filled in years of experience as a church leader. The Questionnaire also included church-related information questions as follows: Denomination, Role/position in the church, weekly church attendance, and involvement in church activities. The participant filled in the denomination. Role/position in the church, weekly church attendance, and involvement in church activities were organized into categories for participants to select.

Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001)

The Patient Health Questionnaire-9 (PHQ-9) is a widely used self-reporting measure for assessing the severity of depression. It consists of nine (9) items corresponding to the DSM-IV diagnostic criteria for major depressive disorder. The PHQ-9 is scored on a scale from 0 to 27, with higher scores indicating greater severity of depressive symptoms. The internal reliability of the PHQ-9 was excellent, with a Cronbach's α of 0.89 (Kroenke et al., 2001). Test-retest reliability within 48 hours is also excellent, with a Cronbach's α of 0.84 (Kroenke et al., 2001). This suggests that the items of the questionnaire measure the same underlying construct (depression) and are reliable in consistently assessing depressive symptoms. The PHQ-9 was developed based on the DSM-IV criteria for major depressive disorder, ensuring that it covers the key symptoms of depression. The PHQ-9 has demonstrated good criterion validity and correlates well with other established measures of depression severity. It has been shown to have a high sensitivity and specificity for detecting major depressive disorder compared to structured clinical interviews. Additionally, it has been found to be sensitive to changes in depressive symptoms over time, indicating its responsiveness. The PHQ-9 has shown good reliability and validity, making it a reliable and valid tool for assessing the severity of depressive symptoms in clinical and research settings. The PHQ-9 is available to the public; no permission is required for this research.

Generalized Anxiety Disorder-7 (GAD-7; Spitzer et al., 2006)

Generalized Anxiety Disorder-7 (GAD-7) is a self-reporting measure designed to assess the severity of generalized anxiety disorder symptoms. It consists of seven (7) items corresponding to the DSM-IV diagnostic criteria for generalized anxiety disorder. The GAD-7 is scored on a scale from 0 to 21, with higher scores indicating greater severity of anxiety symptoms. The GAD-7 has shown excellent internal consistency, with a Cronbach's alpha coefficient 0.92. Test-retest reliability is also good, with an intraclass correlation of 0.83 (Spitzer et al., 2006). This indicates that the items of the questionnaire measure the same underlying construct (anxiety) and are reliable in consistently assessing anxiety symptoms. The GAD-7 was developed based on the DSM-IV criteria for generalized anxiety disorder, ensuring it covers the key anxiety symptoms. The GAD-7 has demonstrated good criterion validity. It correlates well with other established measures of anxiety severity. It has been shown to have a high sensitivity and specificity for detecting generalized anxiety disorder compared to structured clinical interviews. The construct validity was tested with exploratory and confirmatory factor

analysis, which resulted in the KMO coefficient of 0.915, which surpasses the recommended value of 0.6 (Spitzer et al., 2006). It has also been found to be sensitive to changes in anxiety symptoms over time, which indicates its responsiveness. The GAD-7 has shown good reliability and validity, making it a reliable and valid tool for assessing the severity of generalized anxiety disorder symptoms in clinical and research settings. The GAD-7 is available to the public, and no permission is required for this research.

Mental Health Awareness Questions

All participants in this experimental study in both groups completed the Mental Health Awareness Questions created and found in Appendix F to better understand each participant's level of awareness. There are 12 questions for each participant to answer. Each question will be allotted one point: 0-3 points for the participant who has no mental health awareness, 4-8 points for the participant who has some mental health awareness, and 9-12 points for the participant who has mental health awareness. These questions were created to collect quantitative data and be able to measure mental health awareness in this experimental study.

Schutte Self-Reporting Emotional Intelligence Test (SSEIT; Schutte et al., 1997)

The Schutte Self-Reporting Emotional Intelligence Scale (SSEIT) is comprised of 33 questions (Appendix G). The SSEIT has been found to have good internal consistency, indicating that the items within the test measure the same construct. The Cronbach's alpha coefficient for the SSEIT is reported to range from 0.85 to 0.88, suggesting a high reliability level. The SSEIT has demonstrated good convergent validity. Its scores correlate positively with other measures of emotional intelligence. It has been found to have significant positive correlations with measures such as the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT) and the Emotional Quotient Inventory (EQ-i). This indicates that the SSEIT measures a similar construct to other established emotional intelligence assessments. The SSEIT has also shown discriminant validity, as it has been found to have low correlations with measures of unrelated constructs, such as cognitive ability tests. This suggests that the SSEIT is specific to emotional intelligence and is not heavily influenced by other factors. It is important to note that the SSEIT is a self-reporting measure that relies on individuals accurately reporting their emotional intelligence. Various factors can influence self-reporting measures, such as social desirability bias

or individuals' perception of their own emotional intelligence. Therefore, while the SSEIT has demonstrated good reliability and validity, it is always important to interpret the results cautiously and consider other sources of information when assessing emotional intelligence. This measure is public and can be used if the author is acknowledged per the directions on the Consortium for Research on Emotional Intelligence in Organizations website.

Open-ended Questions

Upon completing the five-week intervention, only the participants assigned to The Emotionally Healthy Leader group answered the following questions found in Appendix H:

1. How has participating in *The Emotionally Healthy Leader* Intervention Program impacted your overall well-being and emotional health as a leader?

2. Can you provide specific examples or changes you have noticed in your leadership style or behavior?

3. In what ways has *The Emotionally Healthy Leader* Intervention Program helped you improve your relationships with team members and congregants?

4. Have you noticed any changes in how you communicate, listen, or handle conflicts within your leadership role?

5. Can you share any strategies or tools you have learned from *The Emotionally Healthy Leader* Intervention Program that have been particularly effective in your mental health, awareness, and emotional intelligence as a leader?

6. How have these strategies impacted your ability to lead effectively in challenging situations?

The participants not assigned to *The Emotionally Healthy Leader* will not answer these questions.

Operationalization of Variables

Mental Health—is an ordinal variable that will be measured using the Mental Health Inventory (MHI; Veit & Ware, 1983).

Emotional Intelligence—is an ordinal variable that will be measured using the Emotional Intelligence Scale (EIS; Schutte et al., 1998).

Participation in *The Emotionally Healthy Leader*—is an ordinal variable where participants can be categorized into ordinal categories based on their level of participation, such as "completed" or "not completed."

Ethnicity/Cultural Background—is a nominal variable where participants' self-identified Latino ethnicity or cultural background can be categorized into different groups, such as Mexican, Puerto Rican, Cuban, etc.

Age—is a ratio variable on the Demographic Questionnaire, where participants' age can be measured as a continuous variable, allowing for calculations of ratios (e.g., one participant is twice the age of another participant).

Years of Experience as a church leader—is a ratio variable where participants' self-reported years of experience as a church leader can be measured as a continuous variable, allowing for calculations of ratios (e.g., one participant has three times the experience of another participant).

Data Analysis

Descriptive statistics was used for this quantitative experimental study. The mean, median, and range of mental health scores, mental health awareness scores, and emotional intelligence scores for the sample of Latino church leaders will be calculated. These descriptive statistics are presented in a table, along with any other relevant demographic information, such as age, gender, education level, and years of experience as Latino church leaders. Descriptive statistics are essential in quantitative studies, as they clearly summarize the data collected. In this research, descriptive statistics explains the distribution of mental health and emotional intelligence scores within the sample. This information provides an initial overview of the data and identifies any potential outliers or patterns.

The participants were divided into two groups: (a) participants in *The Emotionally Healthy Leader* and (b) non-participants. An independent samples T-test was conducted to compare each group's mental health and emotional intelligence scores. The null hypothesis (H_0) is that there is no difference in mental health and emotional intelligence scores between the two groups, while the alternative hypothesis (H_a) suggests that there is a significant difference between the two groups upon the completion of *The*

Emotionally Healthy Leader. The t-value, degrees of freedom, and p-value for the t-test were calculated. The results were evaluated based on the significance level (e.g., $p < 0.05$). The MANOVA allows the data to analyze the relationship between multiple dependent variables and one or more independent variables simultaneously. By dividing the sample into two groups (participation in *The Emotionally Healthy Leader* versus no participation), the research examined whether there is a significant difference in mental health and emotional intelligence scores between these groups. This analysis is particularly relevant in understanding the potential impact of mental health on emotional intelligence in Latino church leaders. The combination of descriptive statistics and MANOVA analysis procedures provides a comprehensive approach to understanding and analyzing mental health's effects on Latino church leaders' emotional intelligence.

Delimitations, Assumptions, and Limitations

Delimitations

This study delimits its sample size to a specific number of participants, such as a minimum of 52 Latino church leaders participating in this experimental study, with only half of the participants (N=26) participating in *The Emotionally Healthy Leader*. Limiting the sample size helped ensure that the study remained manageable within the available resources and time constraints. It allowed for a more focused analysis of a feasible number of participants, ensuring that data collection, analysis, and interpretation can be carried out effectively. This study delimits the timeframe for data collection, focusing on a specific period during which the effects of mental health on emotional intelligence will be assessed. Delimiting the timeframe helped establish a clear data collection and analysis time boundary. This allowed the examination of the impact of mental health on emotional intelligence within a specific period, reducing the potential influence of external factors or changes over time that may affect the results. This study delimits its sample to participants from the Latino community. Delimiting the sample by cultural background allows for a more homogenous group with shared cultural experiences and values. This helped better understand the specific context in which mental health and emotional intelligence are influenced among Latino church leaders, providing more nuanced and culturally relevant findings.

Assumptions

There is a relationship between mental health and emotional intelligence among Latino church leaders. Previous research has shown a correlation between mental health and emotional intelligence in various populations. It is reasonable to assume that this relationship also exists among Latino church leaders. Participation in *The Emotionally Healthy Leader* will improve emotional intelligence among Latino church leaders. *The Emotionally Healthy Leader* is specifically designed to enhance emotional intelligence and mental health awareness among church leaders. Previous studies on similar programs have demonstrated their effectiveness in improving various populations' emotional intelligence and mental health awareness. It is reasonable to assume that this program will also positively impact emotional intelligence among Latino church leaders. Latino church leaders experience specific mental health challenges that may affect their emotional intelligence. Studies have shown that Latino individuals, including church leaders, may face unique mental health stressors, such as acculturation stress, discrimination, and cultural expectations. These factors can potentially impact emotional intelligence. Therefore, it is reasonable to assume that these challenges may influence emotional intelligence among Latino church leaders. The sample of Latino church leaders participating in the study is representative of the wider population of Latino church leaders. It is assumed that the appropriate sampling techniques have been followed to ensure a representative sample of Latino church leaders. This assumption is crucial to generalize the study's findings to the broader population of Latino church leaders. The mental health and emotional intelligence measurement tools used in the study are valid and reliable for assessing mental health and emotional intelligence among Latino church leaders. The measurement tools chosen are assumed to be culturally sensitive and validated for assessing Latino individuals' mental health and emotional intelligence. This assumption is necessary to ensure that the study accurately captures the participants' mental health and emotional intelligence levels.

Limitations

Generalizability of findings. This experimental study focused specifically on Latino church leaders who participated in *The Emotionally Healthy Leader*. Therefore, the findings may not be applicable to other populations or church leaders who do not engage in similar programs. Another limitation is self-reporting bias. This study relied on self-reporting measures to assess mental health and

emotional intelligence. Self-reporting measures are subject to biases, such as social desirability or inaccurate self-perception. This limitation may impact the accuracy of the data collected. Potential confounding variables are another limitation of this study. This study may not account for all potential confounding variables that could influence both mental health and emotional intelligence. Factors such as age, gender, previous mental health treatment, or personal life circumstances could impact the results but may not be adequately controlled for in the study design. Another limitation of this study is limited long-term follow-up. This study did not include a long-term follow-up to assess the sustained effects of *The Emotionally Healthy Leader* on emotional intelligence and mental health. It is unclear whether any observed changes are temporary or have a lasting impact. Limitations within this study also include cultural and contextual factors. This study may not fully consider the cultural and contextual factors influencing mental health and emotional intelligence among Latino church leaders. These factors could include cultural values, religious beliefs, or specific challenges this population faces, which could impact the study's findings.

Summary

This chapter outlined the study design, data collection methods, sample characteristics, and data analysis techniques. This study design is experimental, with participants randomly assigned to either the intervention group (those who participate in *The Emotionally Healthy Leader*) or the control group (those who do not participate in *The Emotionally Healthy Leader*). This design allowed for comparing emotional intelligence and mental health changes between the two groups. Data collection methods involved using self-reporting measures to assess mental health, mental health awareness, and emotional intelligence, which provide quantitative data on these variables. The sample consisted of Latino church leaders who met specific inclusion criteria, such as being actively involved in leadership roles within their churches and having no previous participation in similar programs. The recruitment process and ethical considerations, such as obtaining informed consent, were also discussed. “Above all else, guard your heart, for everything you do flows from it.” (*New Living Translation*, 2015, Proverbs 4:23). This biblical reference and principle demonstrate the importance of mental health, mental health awareness, and emotional intelligence. The quantitative data collected from this experimental study will be reviewed and analyzed to present the findings clearly, logically, and comprehensively in the results section.

CHAPTER 4: RESULTS

Overview

This research aims to examine the relationship between mental health awareness and emotional intelligence among Latino church leaders and determine whether *The Emotionally Healthy Leader* intervention significantly impacts these constructs. To assess this, this research will measure the participants' mental health awareness and emotional intelligence levels before and after the intervention using validated assessment tools and surveys. By measuring the participants' levels of mental health awareness and emotional intelligence before and after the intervention, the study will provide insights into the effectiveness of the intervention program in increasing knowledge about mental health and enhancing emotional intelligence among Latino church leaders.

By examining this population of Latino church leaders, this study recognizes their unique challenges in balancing their mental health and emotional intelligence with their role as spiritual leaders. This research study hypothesizes a strong link between Latino church leaders' mental health and emotional intelligence and that understanding this relationship can have significant implications for research and future interventions.

This research used surveys and questionnaires to gather quantitative data on the participating Latino church leaders' mental health indicators and emotional intelligence levels. These surveys will include self-reporting scales, assessing aspects such as depression and anxiety and emotional intelligence competencies such as self-awareness, self-regulation, empathy, relationship management, and mental health awareness questions. By uncovering the connection between mental health and emotional intelligence, this research hopes to contribute to the existing body of knowledge in psychology, specifically in the context of Latino church leadership.

This study has the potential to highlight the importance of mental health support and interventions for church leaders, ultimately enhancing their overall emotional intelligence and mental health. Furthermore, the results can inform the development of targeted intervention or training programs and resources to foster emotional intelligence skills and mental health awareness among Latino church leaders. This knowledge can positively impact their effectiveness in providing support, guidance, and care to their congregations and promoting their self-care and resilience.

This research study overall has great potential in advancing our understanding of the effects of mental health on emotional intelligence among Latino church leaders. The data collected will provide valuable insights, furthering the research hypothesis and potentially leading to practical interventions that promote emotional intelligence and mental health awareness among Latino church leaders.

Research Questions

RQ1: Would *The Emotionally Healthy Leader* training significantly increase mental health awareness in Latino church leaders compared to the control group?

The multivariate test results indicate a significant effect of *The Emotionally Healthy Leader* intervention on mental health awareness among Latino church leaders compared to the control group $F(4, 47) = 2.893$, $p = .032$, $\eta^2_{part} = .198$, therefore rejecting the null hypothesis (H_0) with a 95% confidence level and accepting the alternative hypothesis (H_1).

RQ2: Would *The Emotionally Healthy Leader* training significantly increase emotional intelligence in Latino church Leaders compared to the control group?

The results of the univariate tests demonstrate a significant increase in emotional intelligence among Latino church leaders who underwent *The Emotionally Healthy Leader* intervention compared to the control group $F(1, 1) = 123.953$, $p = <.001$, $\eta^2_{part} = .713$, post-intervention, therefore rejecting the null hypothesis (H_0) with a 95% confidence level and accepting the alternative hypothesis (H_1).

RQ3: Would *The Emotionally Healthy Leader* training significantly decrease depression and anxiety in Latino church leaders compared to the control group?

The results revealed a significant interaction effect between time and group for depression (PHQ-9) and anxiety (GAD-7), $F(4, 47) = 51.665$, $p < 0.001$, $\eta^2_{part} = .815$, therefore rejecting the null hypothesis (H_0) with a 95% confidence level and accepting the alternative hypothesis (H_1).

Hypotheses

Hypothesis 1

H_0: *The Emotionally Healthy Leader* training does not significantly increase mental health awareness in the Latino church leader compared to the control group.

H_1: *The Emotionally Healthy Leader* training significantly increases mental health awareness in the Latino church leader compared to the control group.

Hypothesis 2

H_0: *The Emotionally Healthy Leader* training does not significantly increase emotional intelligence in the Latino church leader compared to the control group.

H_1: *The Emotionally Healthy Leader* training significantly increases emotional intelligence in the Latino church leader compared to the control group.

Hypothesis 3a

H_0: *The Emotionally Healthy Leader* training does not significantly decrease depression in the Latino church leader compared to the control group.

H_1: *The Emotionally Healthy Leader* training significantly decreases depression in the Latino church leader compared to the control group.

Hypothesis 3b

H_0: *The Emotionally Healthy Leader* training does not significantly decrease anxiety in the Latino church leader compared to the control group.

H_1: *The Emotionally Healthy Leader* training significantly decreases anxiety in the Latino church leader compared to the control group.

Descriptive Results

Data was collected through surveys and questionnaires (See appendix D-H for questions) from a total of 52 participants. This study's participants are Latino church leaders within the Christian/Pentecostal denomination. These leaders and pastors were recruited from within the United States and were between the ages of 18-75. This study includes male and female participants. Eleven of the participants were males, and 41 of the participants were females. The average age of the participants was 39 (*SD* = 10.7). The participants in this research study were ethnically diverse, encompassing individuals of Puerto Rican, Dominican, Cuban, and White ethnic backgrounds. Leaders and pastors participating have varying levels of education, ranging from high school diplomas to advanced degrees. They have diverse levels of experience in leadership roles within their church, ranging from a minimum of three months to those with several years of experience. In this study, out of the total participants, 10 individuals identified as single, while the remaining 42 participants reported being married. Participants come from different socioeconomic backgrounds and represent a range of income levels and occupations. The participants' range of church leadership experience varied, with the least experienced individual having one year of experience, while the most experienced participants reported over 20 years of church leadership experience. To protect the confidentiality of the participants, they were numbered RP1 through RP52, with their specific information attached to their fictitious IDs. In this research, all participants were actively serving in a Latino church and participated in all questionnaires and surveys to determine their mental health awareness and emotional intelligence prior to being assigned to a group and again once the intervention was completed.

The data collected has been interpreted as related to the research questions. The first research question asked: Would *The Emotionally Healthy Leader* training significantly increase mental health awareness in the Latino church leader compared to the control group? The data presented that the participants assigned to the intervention group became more aware of their mental health in comparison to the participants assigned to the control group. The statistics showed that there was a significant increase in the participants assigned to the intervention group mental health awareness.

The second question asked: Would *The Emotionally Healthy Leader* training significantly increase the emotional intelligence of Latino church leaders compared to the control group? The data presented showed that the participants assigned to the intervention group became more aware of their emotional intelligence. However, the data did not show a significant difference in emotional intelligence between the intervention group and the control group.

Each group was comprised of 26 participants, for a total of 52 participants. For the pre-intervention PHQ-9 scores, the mean score for the Intervention Group was 1.577 (*SD* = 0.643), whereas the No Intervention Group had a mean of 1.731 (*SD* = 0.604). The overall mean for both groups combined was 1.654 (*SD* = 0.623). Following the five-week intervention, the mean PHQ-9 score decreased for the Intervention Group (*M* = 1.115, *SD* = 0.326) and increased for the No Intervention Group (*M* = 1.615, *SD* = 0.571), resulting in a combined mean of 1.365 (*SD* = 0.525).

For the pre-intervention GAD-7 scores, the Intervention Group had a mean score of 1.654 (*SD* = 0.936), while the No Intervention Group had a higher mean of 1.962 (*SD* = 1.038). The overall mean across both groups was 1.808 (*SD* = 0.991). After the intervention, the mean GAD-7 score decreased for the Intervention Group (*M* = 1.192, *SD* = 0.491) and increased for the No Intervention Group (*M* = 1.846, *SD* = 0.925), resulting in a combined mean of 1.519 (*SD* = 0.804).

For the emotional intelligence variable (SSEIT scores), the mean pre-intervention score for the Intervention Group was 118.500 (*SD* = 11.332), and for the No Intervention Group, it was 119.692 (*SD* = 8.712). The overall mean across both groups was 119.096 (*SD* = 10.026). Post-intervention, the mean SSEIT score increased for the Intervention Group (*M* = 123.615, *SD* = 11.583) and showed a marginal increase for the No Intervention Group (*M* = 119.039, *SD* = 8.911), resulting in a combined mean of 121.327 (*SD* = 10.48944).

Finally, for the mental health awareness (MHA scores), the mean pre-intervention score for the Intervention Group was 7.846 (*SD* = 1.666), and for the No Intervention Group, it was 8.039 (*SD* = 1.455). The overall mean across both groups was 7.942 (*SD* = 1.552). Post-intervention, the mean MHA score increased for the Intervention Group (*M* = 9.615, *SD* = 1.388) and showed a smaller increase for the No Intervention Group (*M* = 8.154, *SD* = 1.437), resulting in a combined mean of 8.884 (*SD* = 1.580). These detailed

descriptive statistics provide a comprehensive overview of the distribution of scores for each variable within and between the intervention and control groups. Descriptive statistics are presented in Table 1.

Table 1

Descriptive Statistics

	Group	Mean	Std. Deviation	N
Pre_PHQ_9_Score	Intervention Group	1.576	.643	26
	No Intervention Group	1.731	.604	26
	Total	1.654	.623	52
Post_5wks_PHQ_9_Score	Intervention Group	1.115	.326	26
	No Intervention Group	1.615	.571	26
	Total	1.365	.525	52
Pre_GAD_7_Score	Intervention Group	1.654	.936	26
	No Intervention Group	1.961	1.038	26
	Total	1.808	.991	52
Post_5wks_GAD_7_Score	Intervention Group	1.192	.491	26
	No Intervention Group	1.846	.925	26
	Total	1.519	.804	52
Pre_SSEIT_Score	Intervention Group	118.500	11.332	26
	No Intervention Group	119.692	8.712	26
	Total	119.096	10.026	52
Post_5wks_SSEIT_Score	Intervention Group	123.615	11.583	26
	No Intervention Group	119.039	8.911	26
	Total	121.327	10.489	52
Pre_MHA_Score	Intervention Group	7.846	1.666	26
	No Intervention Group	8.039	1.455	26
	Total	7.942	1.552	52
Post_5wks_MHA_Score	Intervention Group	9.615	1.388	26
	No Intervention Group	8.154	1.434	26
	Total	8.885	1.580	52

Study Findings

MANOVA

A Multivariate Analysis of Variance (MANOVA) was conducted to examine the overall effects *The Emotionally Healthy Leader* Intervention had on increasing mental health and emotional intelligence in the intervention group. Significant differences were found between groups (intervention versus control) in the overall mental health and emotional intelligence scores for the PHQ-9, GAD-7, SSEIT, and MHA. The effect size indicated a medium effect. Significant differences were found over time, pre- and post-intervention, across all measured variables. Effect size indicated a medium effect. A significant interaction effect was observed between time and group, suggesting that the intervention influenced the changes over time. Effect size indicated a medium effect.

Main Effects of Group

For the between-subjects effect, the analysis yielded a group Wilk's Lambda = 0.802, $F(4, 47) = 2.893$, $p = .032$. The Wilk's Lambda value, close to 1, suggests minimal differences between the groups. The multivariate η^2_{part} based on Wilk's Lambda indicated a medium effect size, $\eta^2_{part} = .198$ (Warner, 2013, p. 208), for the main effect of the group on PHQ9, GAD-7, SSEIT, and MHA. The null hypothesis was rejected at a 95% confidence level.

Main Effect of Time

For the within-subjects effect, the analysis yielded a Wilk's Lambda for time = 0.171, $F(4, 47) = 57.120$, $p < 0.001$. The Wilk's Lambda value, close to 0, suggests significant differences between the times. The multivariate η^2_{part} based on Wilk's Lambda indicated a medium effect size, $\eta^2_{part} = .829$ (Warner, 2013, p. 208), for the main effect of time on PHQ9, GAD-7, SSEIT, and MHA. The null hypothesis was rejected at a 95% confidence level.

Interaction Effect Between Time and Group

The analysis yielded a Wilk's Lambda for the interaction between time and group = 0.185, $F(4, 47) = 51.665$, $p < 0.001$. The Wilk's Lambda value, close to 0, suggests substantial differences in the interaction levels between times and groups. The multivariate η^2_{part} based on Wilk's Lambda indicated a medium effect size, $\eta^2_{part} = .815$ (Warner, 2013, p. 208), for the interaction effect between time and group on PHQ9, GAD-7, SSEIT, and MHA. The null hypothesis was rejected at a 95% confidence level. Table 2 for the Multivariate Tests.

Table 2

Multivariate Tests[a]

Effect			Value	*F*	Hypothesis d*f*	Error d*f*	Sig.	Partial Eta Squared
Between Subjects	Intercept	Pillai's Trace	.995	2558.048[b]	4.000	47.000	<.001	.995
		Wilks' Lambda	.005	2558.048[b]	4.000	47.000	<.001	.995
	Group	Pillai's Trace	.198	2.893[b]	4.000	47.000	.032	.198
		Wilks' Lambda	.802	2.893[b]	4.000	47.000	.032	.198
Within Subjects	Time	Pillai's Trace	.829	57.120[b]	4.000	47.000	<.001	.829
		Wilks' Lambda	.171	57.120[b]	4.000	47.000	<.001	.829
	Time *	Pillai's Trace	.815	51.665[b]	4.000	47.000	<.001	.815
	Group	Wilks' Lambda	.185	51.665[b]	4.000	47.000	<.001	.815

Note. a. Design: Intercept + Group, Within Subjects Design: Time; b. Exact Statistic

Univariate Tests

Significant changes were found in PHQ-9, GAD-7, SSEIT, and MHA scores over time, with varying effect sizes ranging from small to medium. Interaction effects were observed in PHQ-9, GAD-7, SSEIT, and MHA scores, indicating that the intervention had a differential impact on the two groups. Effect sizes ranged from small to medium.

Main Effects

Multivariate Analysis of Variance (MANOVA) was conducted to examine the effect of time on four dependent variables: Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7), Schutte Self-Reporting Emotional Intelligence Test (SSEIT), and Mental Health Assessment (MHA). The analysis for the PHQ-9 revealed a significant effect of time, $F(1,50) = 23.734$, $p < .001$, $\eta^2_{part} = .322$. This supports the idea of the alternate hypothesis of Hypothesis 1 that mental health awareness increases with *The Emotionally Healthy Leader* Intervention, rejecting the null hypothesis because there was a significant change in PHQ-9 scores over time. The effect of time for the GAD-7 was significant, $F(1,50) = 16.496$, $p < .001$, $\eta^2_{part} = .248$, suggesting a meaningful change in GAD-7 scores over time. The null hypothesis is rejected as the analysis supports the idea of the alternate hypothesis for hypothesis 1 that mental health awareness increases with *The Emotionally Healthy Leader* Intervention. The effect of time was highly significant for the SSEIT, $F(1,50) = 74.130$, $p < .001$, $\eta^2_{part} = .597$, indicating a substantial change in SSEIT scores over time. The null hypothesis is rejected as the analysis supports the idea of the alternate hypothesis for Hypothesis 2 that emotional intelligence increases with *The Emotionally Healthy Leader* Intervention. Lastly, the effect of time was highly significant for the MHA, $F(1,50) = 84.661$, $p < .001$, $\eta^2_{part} = .629$, indicating a considerable change in MHA scores over time. The null hypothesis is rejected as the analysis supports the idea of the alternate hypothesis for Hypothesis 2 that mental health awareness increases with *The Emotionally Healthy Leader* Intervention. These findings suggest that time had a statistically significant impact on PHQ-9, GAD-7, SSEIT, and MHA scores, with medium to small effect sizes across the variables.

Interaction effects

Multivariate Analysis of Variance (MANOVA) was conducted to examine the interaction effect between time and group on four dependent variables: Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7), Schutte Self-Reporting Emotional Intelligence Test (SSEIT), and Mental Health Assessment (MHA). The analysis revealed a significant interaction effect between time and group for the PHQ-9, $F(1,50) = 8.544$, $p = 0.005$, $\eta^2_{part} = .146$. The effect size, $\eta^2_{part} = .146$, was small. The null hypothesis is rejected, indicating a significant interaction effect. The interaction effect between time and group was significant for the GAD-7, $F(1,50) = 5.938$, $p = 0.018$, $\eta^2_{part} = .106$. The effect size, $\eta^2_{part} = .106$, was small. The null hypothesis is rejected, suggesting a

meaningful interaction effect. The interaction effect between time and group was highly significant for the SSEIT, $F(1,50) = 123.953$, $p < .001$, $\eta^2_{part} = .713$. The effect size, $\eta^2_{part} = .713$, was medium, indicating a substantial interaction effect. Lastly, the interaction effect between time and group was highly significant for the MHA, $F(1,50) = 65.197$, $p < .001$, $\eta^2_{part} = .566$. The effect size, $\eta^2_{part} = .566$, was medium, suggesting a considerable interaction effect. These findings suggest that the interaction effect between time and group significantly influenced PHQ-9, GAD-7, SSEIT, and MHA scores, with small to medium effect sizes across the variables. See Table 3 for Univariate Tests.

Table 3

Univariate Tests

Source	Measure		Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Time * Group	PHQ	Sphericity Assumed	.779	1	.779	8.544	.005	.146
	GAD	Sphericity Assumed	.779	1	.779	5.938	.018	.106
	SSEIT	Sphericity Assumed	216.346	1	216.346	123.953	<.001	.713
	MHA	Sphericity Assumed	17.779	1	17.779	65.197	<.001	.566

Figure 3 showed that before the intervention, both the intervention group and the control had similar PHQ-9 scores. The similarity was evidenced by the overlapping error bars. However, the graph indicated a significant decrease in the PHQ-9 score among the intervention group. The 95% CI error bars in the post intervention time were not overlapping, implying that the change in mental health, as measured using the PHQ-9 score, for the intervention group was significantly different from that of the control group. Therefore, the intervention caused a significant change in mental health when measured using the PHQ-9 scale.

Figure 3

Means of PHQ-9 Scores Pre and Post-Intervention

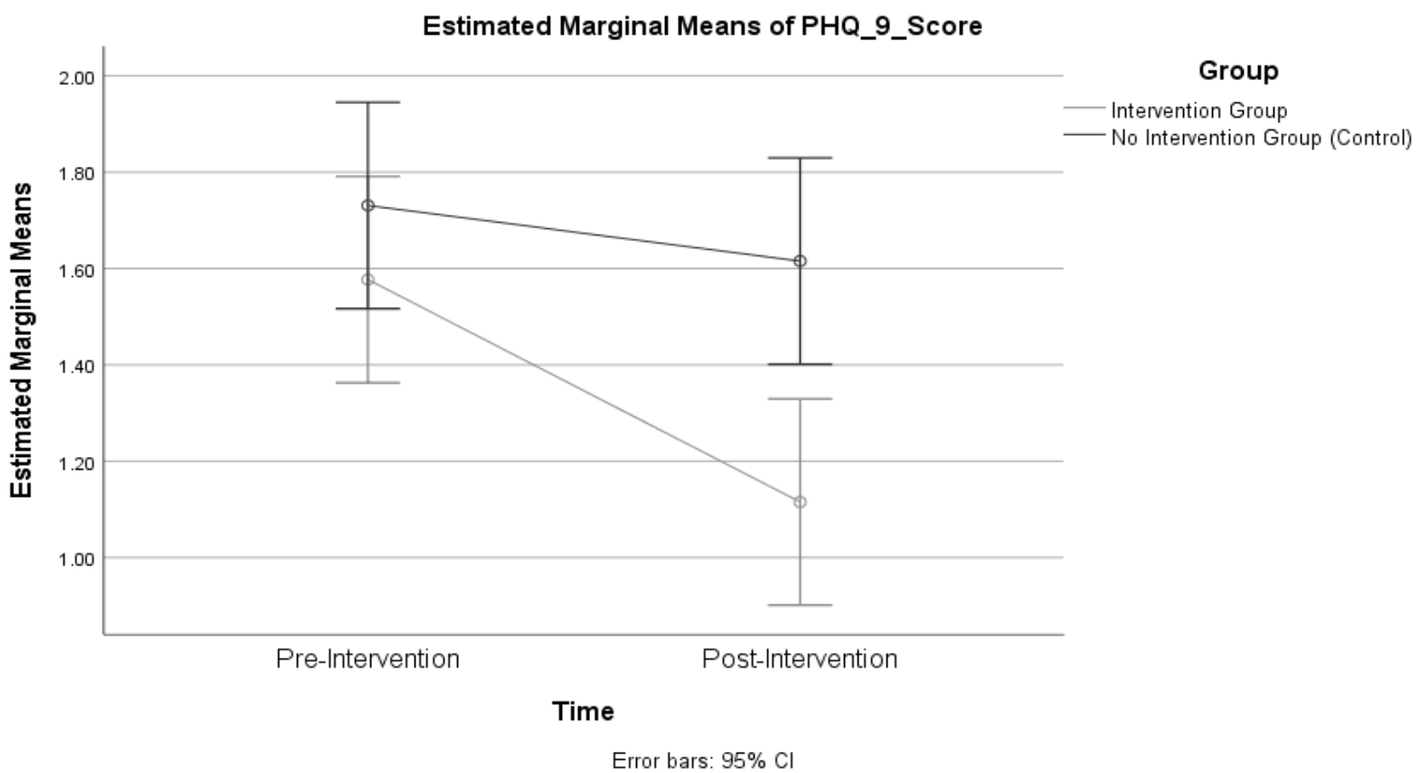


Figure 4 showed that before the intervention, both the intervention group and the control had similar scores for GAD-7. The similarity was evidenced by the overlapping error bars. However, the graph indicated a notable decrease in the GAD-7 score among the intervention group. The 95% CI error bars in the post intervention time were slightly overlapping, implying that the change in mental health, as measured using the GAD-7 score, for the intervention group was not significantly different from that of the control group. The intervention caused insignificant changes in mental health when measured using the GAD-7 scale.

Figure 4

Means of GAD-7 Scores Pre- and Post-Intervention

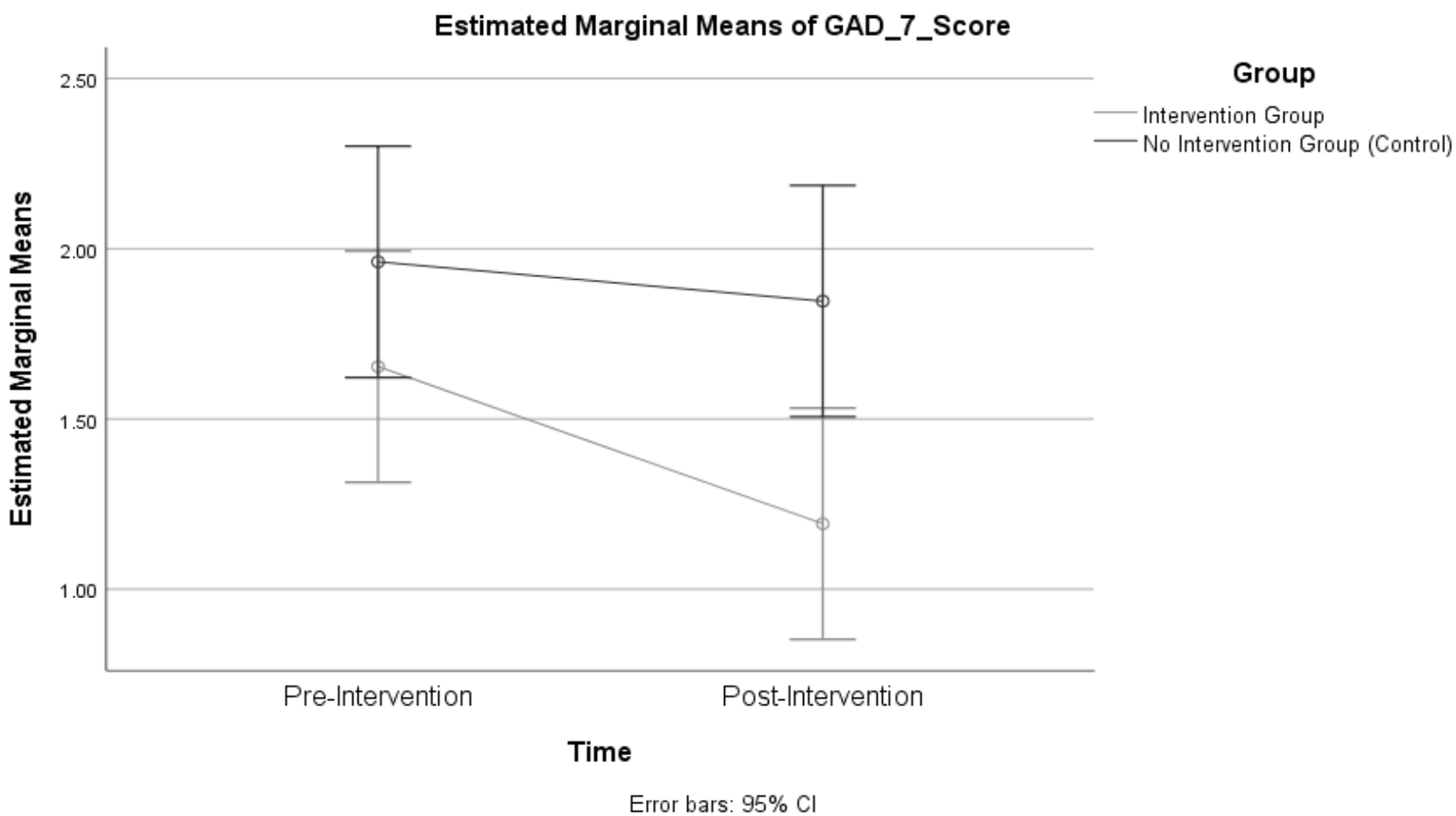


Figure 5 shows that before intervention, both the intervention group and the control had similar scores for MHA. The similarity was evidenced by the overlapping error bars. However, the graph indicated a significant increase in the MHA score among the intervention group. The error bars in the post intervention time were not overlapping, implying that the increase in mental health, as measured using the MHA score, for the intervention group was significantly different from that of the control group. Hence, the intervention caused a significant increase in mental health when measured using the MHA scale.

Figure 5

Means of MHA Scores Pre- and Post-Intervention

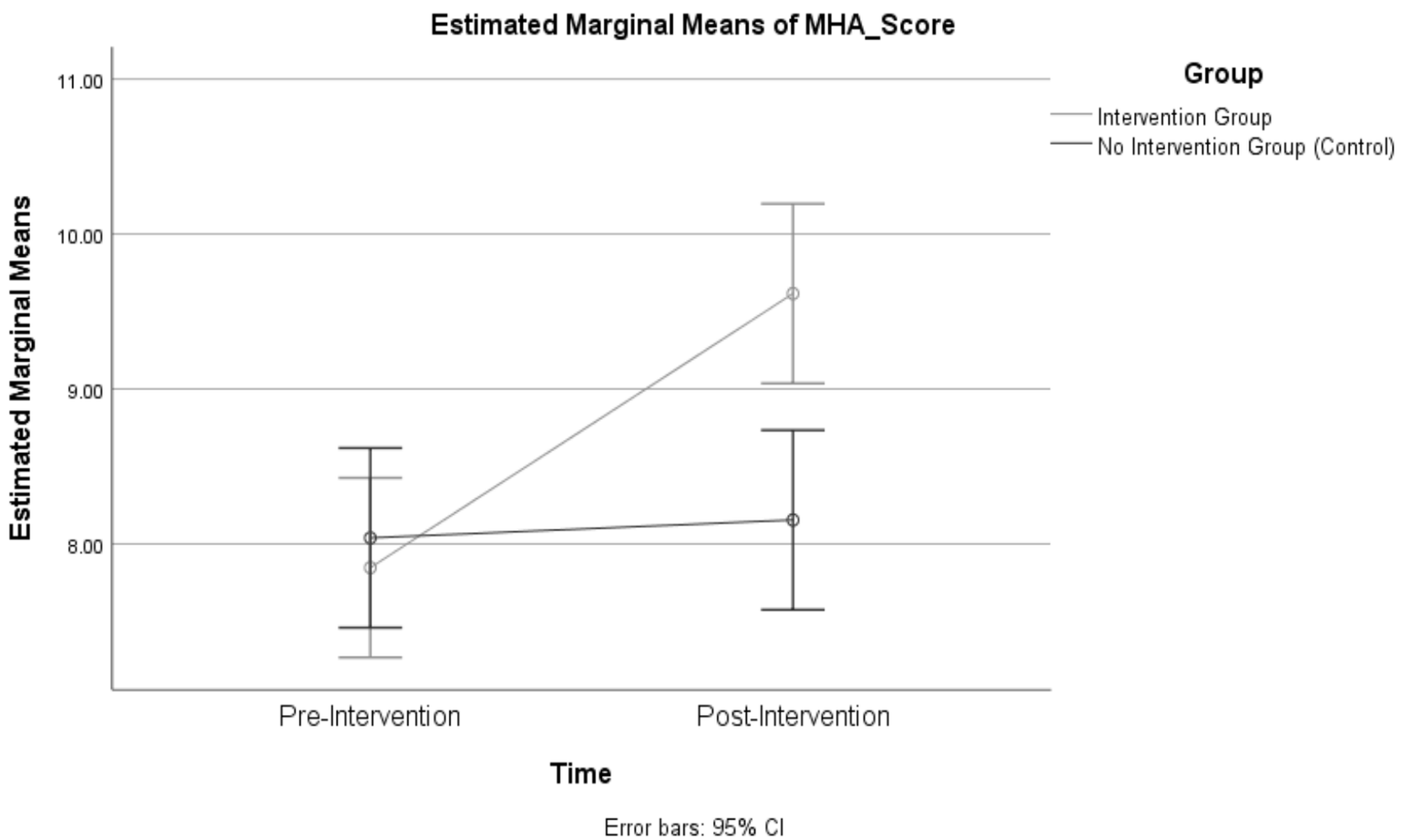
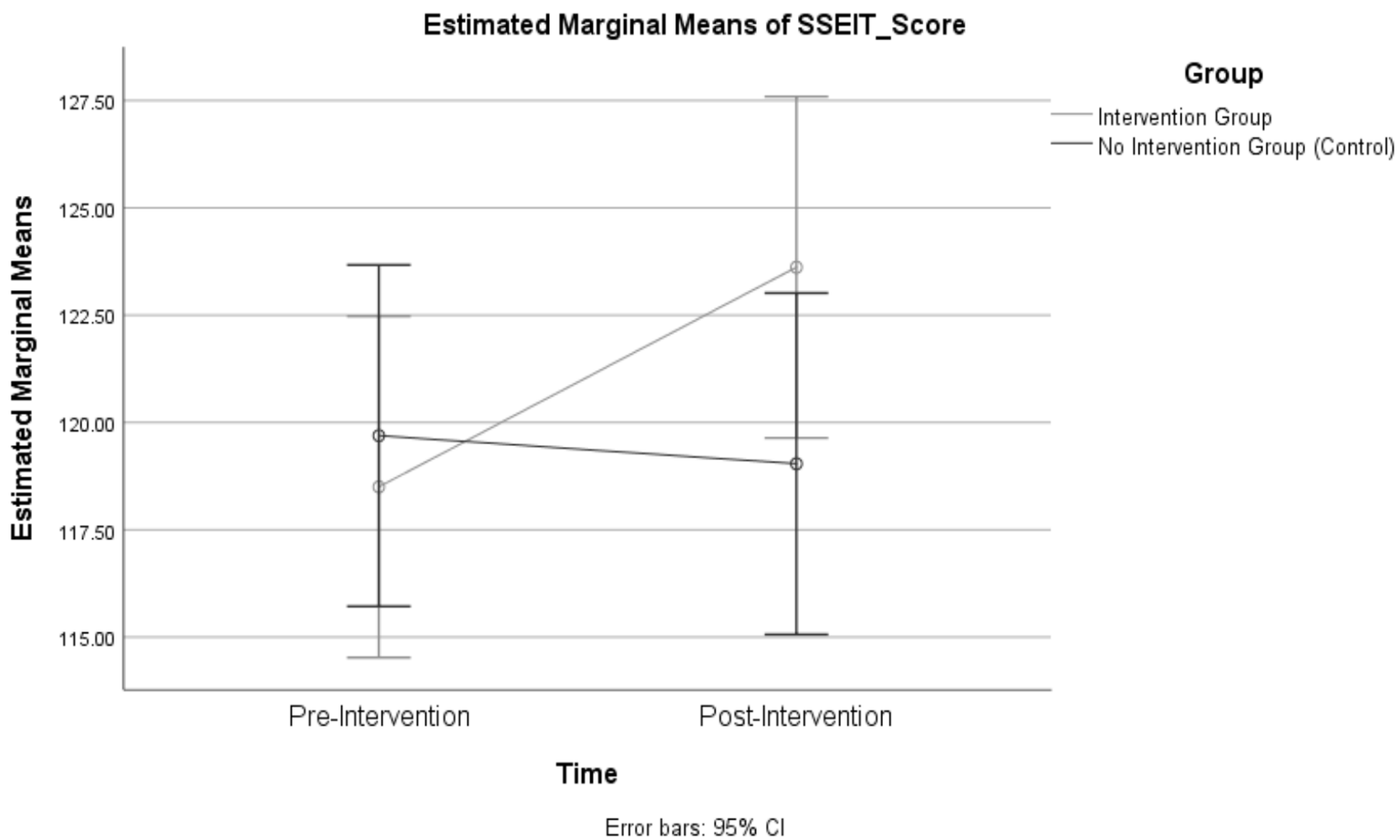


Figure 6 shows that before the intervention, both the intervention group and the control had similar scores for SSEIT. The similarity was evidenced by the overlapping error bars. The graph indicated an increase in the SSEIT score among the intervention group. However, since the error bars in the post intervention time were also overlapping, the graph indicated that the increase in emotional intelligence, as measured using the SSEIT score, for the intervention group was not significantly different from that of the control group. Hence, the intervention did not cause a significant increase in emotional intelligence, as measured using the SSEIT scale.

Figure 6

Means of SSEIT Score Pre- and Post-Intervention



Summary

The Emotionally Healthy Leader Intervention proved to have a significant impact on mental health, as measured by PHQ-9, GAD-7, and MHA scores but had a limited impact on emotional intelligence (SSEIT). The interaction effects indicated that the intervention group influenced the changes observed over time, emphasizing the intervention's effectiveness. The findings suggest a nuanced impact on different aspects of mental health and emotional intelligence, providing valuable insights for future interventions or studies in this area.

CHAPTER 5: DISCUSSION

Overview

This study aims to investigate the effectiveness of *The Emotionally Healthy Leader* as an intervention to increase mental health awareness and emotional intelligence in Latino church leaders. It seeks to explore the specific challenges and stressors faced by Latino church leaders that may impact their mental health and emotional well-being. It seeks to understand the potential benefits of enhancing emotional intelligence to promote better mental health and emotional well-being among Latino church leaders.

The preceding chapters have unfolded a detailed exploration into the effectiveness of *The Emotionally Healthy Leader* as an intervention tailored to augment mental health awareness and emotional intelligence among Latino church leaders. Rooted in the initial premise of investigating the nuanced challenges and stressors inherent in the leadership roles of the Latino community, our study has aimed to shed light on the intricacies that may influence their mental health and emotional well-being.

This research seeks to bridge the gap between theory and practice, aiming to not only uncover the specific challenges faced by Latino church leaders but also to discern tangible pathways toward fostering better mental health outcomes within the unique context of their leadership roles. Through a lens of cultural sensitivity and contextual awareness, this investigation contributes valuable insights to the broader discourse on mental health within faith-based leadership, particularly within the Latino community. Ultimately, the goal is to provide an actionable understanding that can inform future interventions, policies, and practices aimed at promoting the mental health and emotional well-being of Latino church leaders.

Summary of Findings

A significant overall effect of *The Emotionally Healthy Leader* Intervention on mental health and emotional intelligence was observed. The group factor demonstrated a medium effect size, indicating a meaningful difference between the intervention and control groups. Time has a substantial impact on mental health and emotional intelligence, with a significant change observed from the pre-intervention to the post-intervention period. The effect size for the time factor was medium, emphasizing the importance of considering temporal changes in the studied variables. The interaction between time and group was statistically significant, highlighting that the

changes over time differed significantly between the intervention and control groups. The interaction effect had a medium effect size, suggesting that the intervention influenced the temporal changes in mental health and emotional intelligence. Significant effects of time were observed for all dependent variables (depression (PHQ-9), anxiety (GAD-7), emotional intelligence (SSEIT), and mental health awareness (MHA)), indicating substantial changes in scores over the intervention period. Effect sizes ranged from small to medium. Interaction effects between time and group were significant for all dependent variables. These effects ranged from small to medium, signifying that the intervention group experienced different changes compared to the control group over time.

The PHQ-9 scores significantly decreased in the intervention group, indicating a significant improvement in mental health. The GAD-7 scores notably decreased in the intervention group, but the change was not significantly different from the control group. The MHA scores significantly increased in the intervention group, suggesting a significant improvement in mental health. The SSEIT scores displayed an increase in emotional intelligence in the intervention group, but the change was not significantly different from the control group. *The Emotionally Healthy Leader* has a meaningful impact on mental health and emotional intelligence, with significant changes observed over time. The results provide support for the effectiveness of the intervention and emphasize its potential to foster positive changes in leaders' mental health and emotional intelligence.

Discussion of Findings

The MANOVA examined the impact of *The Emotionally Healthy Leader* Intervention on mental health and emotional intelligence, utilizing four dependent variables: the PHQ-9, GAD-7, SSEIT, and MHA. The Main effect of group analysis demonstrated a significant between-subjects effect, with a group Wilk's Lambda of 0.802 ($p = 0.032$). This implies that at least one group had a significantly different mean, indicating that *The Emotionally Healthy Leader* Intervention had a differential impact on the two groups. The within-subjects effect showed a significant difference between pre-intervention and post-intervention periods. The associated Wilk's Lambda was 0.171 ($p < 0.001$), signifying substantial differences over time. The interaction effect between time and group was highly significant, Wilk's Lambda of 0.185 ($p < 0.001$), indicating that the intervention impacts over time.

The main effects in the Univariate Tests of the PHQ-9, GAD-7, SSEIT, and MHA showed statistically significant changes over time, with varying effect sizes. The interaction effects between time and group for PHQ-9, GAD-7, SSEIT, and MHA were all statistically significant. These results emphasize that the intervention's effectiveness was influenced by time, demonstrating varied outcomes between intervention and control groups.

Emotional Intelligence

The significant association found between the "Group" factor and emotional intelligence suggests that group membership (i.e., participation in The Emotionally Healthy Leader intervention or being part of the control group) influences emotional intelligence levels. This finding supports the hypotheses and implies that participation in the intervention could potentially enhance emotional intelligence among Latino church leaders, as hypothesized in Hypothesis 2.

The significant association found between the "Group" factor and emotional intelligence in this study aligns with the research of Webb and Chase (2018) regarding the importance of understanding emotional intelligence among clergy. These findings correlate with Webb and Chase (2018) as they focused on clergy as a specific group due to their unique roles, responsibilities, and the emotional demands associated with pastoral care and leadership within religious communities. In this study, the "Group" factor also represents clergy who received The Emotionally Healthy Leader intervention and those who did not. Webb and Chase (2018) found variability in emotional intelligence levels among clergy, highlighting the need for further exploration. Similarly, this study's significant association suggests that group membership (including clergy) can influence emotional intelligence levels. This indicates that emotional intelligence among clergy may indeed vary based on factors such as participation in specific training programs or other group-related dynamics. Lastly, Webb and Chase's (2018) emphasis on understanding emotional intelligence among clergy likely stemmed from the recognition that emotional intelligence is crucial for effective pastoral care, leadership, and overall well-being. This study's findings, particularly the fact that the trained group showed improvements in emotional intelligence, support the notion that targeted training interventions, like The Emotionally Healthy Leader Intervention, can be beneficial for clergy members in enhancing their emotional intelligence skills. This aligns with the broader goal of supporting clergy in their roles and promoting their personal and professional

development. This study's findings regarding the association between group membership and emotional intelligence provide empirical support for the importance of understanding emotional intelligence among clergy, as highlighted by Webb and Chase (2018).

White and Kimmons (2019) emphasize that leaders in the church need to possess emotional intelligence to effectively interact with others. This study's significant association between the "Group" factor and emotional intelligence suggests that emotional intelligence plays a crucial role in how leaders engage with others within the church context. The strong association found in this study between the "Group" factor and emotional intelligence aligns with the emphasis by White and Kimmons (2019) on the importance of emotional intelligence for leaders in the church. These findings correspond with the assertions made by White and Kimmons (2019). White and Kimmons (2019) emphasize the significance of understanding group dynamics, particularly in church leadership. This study's finding of an association between the "Group" factor and emotional intelligence underscores the importance of considering group-related factors when examining emotional intelligence levels among church leaders. It suggests that group membership can influence the development and expression of emotional intelligence skills within the church leadership context. White and Kimmons (2019) advocate for incorporating emotional intelligence training into leadership development programs within the church. This study's findings provide empirical support for this recommendation by demonstrating the association between group membership (potentially including church leaders) and emotional intelligence. This suggests that interventions aimed at enhancing emotional intelligence could be valuable for improving leadership effectiveness and fostering positive interactions within church communities. This study's significant association between the "Group" factor and emotional intelligence aligns with White and Kimmons' (2019) assertions and underscores the relevance of emotional intelligence in the context of church leadership and highlights the potential benefits of integrating emotional intelligence training into leadership development initiatives within religious organizations.

The significant Influence of the "Time" factor and the Interaction between "Time * Group" in this study indicates that emotional intelligence levels can change over time and may vary depending on group membership. This aligns with the idea that emotional intelligence is not static but can be developed and influenced by various factors, including training interventions or experiences within specific groups like church leadership. This finding underscores the importance of considering temporal dynamics, as indicated in the research questions. It suggests that emotional intelligence may naturally evolve over time, but participation in the training could

potentially accelerate this development, as suggested by Hypothesis 2. The interaction between “Time” and “Group” significantly influenced emotional intelligence, indicating that the relationship between time and emotional intelligence varies depending on group membership. This finding further supports the need for temporal considerations, as emphasized in your research questions. It suggests that the impact of time on emotional intelligence may differ between the trained group and the control group, aligning with the hypotheses that the training would increase emotional intelligence (Hypothesis 2).

Overall, the alignment between this study’s findings and the assertions made by White and Kimmons (2019) underscores the importance of emotional intelligence for effective leadership within the church context. It highlights the relevance of understanding emotional intelligence dynamics among church leaders and suggests that interventions aimed at enhancing emotional intelligence could be beneficial for improving leadership effectiveness and interpersonal relations within the church community. Comparing these findings to other studies, research by Ming (2022) and Waglay et al. (2020) also emphasizes the importance of temporal considerations and group dynamics in understanding emotional intelligence. While these studies may not directly relate to the intervention with Latino church leaders, they provide theoretical support for this study’s findings and underscore the broader relevance of temporal and group-related factors in emotional intelligence research. Additionally, the alignment with Webb and Chase’s (2018) research on emotional intelligence among clergy further strengthens the theoretical basis for this study, especially given the focus on church leaders in this study’s research.

The significant effects of time on various measures, such as PHQ-9, GAD-7, SSEIT, and MHA, indicate that these constructs change over time. This finding is particularly relevant to understanding the intricate relationship between temporal aspects and group influences on emotional intelligence, as discussed by Rudolph and Landman (2019) and Smith (2020).

Rudolph and Landman (2019) and Smith (2020) discuss how temporal aspects, such as time and duration, can influence emotional intelligence. This study's findings support their discussion by demonstrating the significant effects of time on emotional intelligence measures (SSEIT) and other constructs. Their studies highlighted the importance of considering temporal dynamics when examining emotional intelligence changes within different groups. The results of this study align with this perspective by showing that emotional intelligence levels can change over time, regardless of group membership. This study’s research questions and hypotheses

(RQ2, Hypotheses 1 and 2) aim to investigate the effects of The Emotionally Healthy Leader Intervention on emotional intelligence and mental health awareness among Latino church leaders compared to a control group. The significant effects of time on emotional intelligence measures suggest that emotional intelligence naturally evolves over time. This finding is crucial for interpreting the effectiveness of the training intervention. Changes observed in emotional intelligence within the trained group were assessed against changes occurring over time within the control group to determine the specific impact of the training. Jankowski et al. (2018) observed significant effects of time on similar measures, with findings suggesting that temporal changes in mental health are related constructs that are consistent across different studies and populations. Jankowski et al. (2018) study findings provide additional support for the reliability and validity of this study's findings, indicating that the observed changes over time are not unique to this study but have been found in other research studies.

The results corroborate the literature suggesting a connection between emotional intelligence and occupational distress (Webb & Chase, 2018). This connection implies that changes in emotional intelligence over time may impact the mental health outcomes and distress levels experienced by clergy. The significant effect of time on emotional intelligence (SSEIT) resonates with literature highlighting the importance of self-awareness for effective ministry (White & Kimmons, 2019). This study's findings are similar to those in White and Kimmons (2019), suggesting that improvements in emotional intelligence, particularly in domains related to self-awareness, may contribute to more effective ministry practices and leadership among clergy members. The significant effect of time on emotional intelligence (SSEIT) also aligns with literature emphasizing the role of emotional intelligence in building relationships and effective leadership (Waglay et al., 2020). These findings suggest that changes in emotional intelligence levels over time may influence clergy members' abilities to building relationships and effective leadership, as seen in the literature by Waglay et al. (2020). The temporal dynamics identified in this study support Ming's (2022) observations regarding the potential harm associated with a lack of emotional intelligence over time. Additionally, the statistical results align with literature emphasizing the demands placed on clergy, the need for self-awareness, and the influence of emotional intelligence on mental health (Rudolph & Landman, 2019; Smith, 2020; Biru et al., 2022).

This study's significance in exploring the multifaceted relationships between emotional intelligence, spiritual leadership, and effective leadership performance resonates with the literature's call for increased awareness and interventions in clergy education (Andrei, 2023; Jankowski et al., 2018). The results of this study suggest that understanding the complex interplay between emotional intelligence and clergy leadership is essential for enhancing clergy education and improving leadership effectiveness. The observations on clergy's personal struggles, attitudes, and responses to congregants mirror the literature's emphasis on the importance of emotional intelligence for effective leadership (Hays & Payne, 2020; Pegram, 2018). The statistical results align with the research, providing empirical evidence for the relationships discussed in the univariate test whose results corroborate the literature by demonstrating significant effects of time on measures related to mental health and emotional intelligence. This study’s findings reinforce the importance of considering temporal dynamics and group influences on emotional intelligence among clergy members, as highlighted in the literature.

Mental Health Awareness

The conducted multivariate and univariate tests provide valuable insights into the relationship between emotional intelligence, mental health awareness, and the various psychological measures examined. The multivariate test indicates a significant effect of the group on emotional intelligence (EI) measures, aligning with previous research emphasizing the importance of emotional intelligence in clergy (Webb & Chase, 2018; Waglay et al., 2020). Webb and Chase (2018) suggest that interventions aimed at enhancing mental health and emotional intelligence among clergy members may be crucial for supporting their effectiveness and well-being in leadership roles within the church community. The significant effect of the group on emotional intelligence observed in this study supports this emphasis by demonstrating that group membership, which includes clergy who received specific training like The Emotionally Healthy Leader intervention, influences emotional intelligence levels and mental health awareness. Waglay et al., (2020) highlighted the importance of emotional intelligence in clergy leadership and relationships within religious communities. The significant effect of the group on emotional intelligence in your study aligns with this emphasis by indicating that group membership (e.g., clergy) plays a role in determining emotional intelligence levels. This alignment suggests that understanding and fostering emotional intelligence among

clergy members can contribute to their ability to build meaningful relationships, navigate interpersonal dynamics, and exhibit effective leadership within their religious communities.

A significant effect of time on psychological measures is observed. This underscores the dynamic nature of emotional intelligence and mental health awareness, supporting the notion that leaders should prioritize ongoing self-assessment (Scazzero, 2015). This finding suggests that mental health awareness can change over time, highlighting the importance of interventions and support systems that promote continuous growth and development. A notable interaction effect between time and group suggests that changes over time differ across groups. This reinforces the need for tailored interventions and support systems for diverse clergy groups (Kansiewicz et al., 2022). This underscores the importance of considering both temporal dynamics and group influences when designing interventions and support programs for clergy members, such as The Emotionally Healthy Leader training.

Mental Health Indicators

The time effect on depression (PHQ-9) scores indicates changes in mental health awareness over time ($p < .001$). This supports the literature emphasizing the link between emotional intelligence and mental health conditions (Webb & Chase, 2018; Ming, 2022). Similar to depression (PHQ-9), significant time effects on GAD-7 scores highlight changes in anxiety levels over time ($p < .001$). This aligns with research emphasizing the role of emotional intelligence in mitigating anxiety among clergy (Rudolph & Landman, 2019). The significant effect on emotional intelligence (SSEIT) scores emphasizes the evolving self-esteem levels among clergy ($p < .001$). This links to literature discussing the importance of clergy's mental well-being in maintaining effective leadership (Venter & Hermans, 2020). Venter and Hermans (2020) emphasize the critical role of mental well-being in the clergy's ability to perform their leadership responsibilities effectively. Their research discusses how clergy's mental health impacts their decision-making, interpersonal relationships, and overall effectiveness in leading their congregations. This study's findings regarding mental health awareness and emotional intelligence support the importance of clergy's mental well-being in maintaining effective leadership. The results suggest that changes in mental health awareness and emotional intelligence over time may influence clergy members' ability to lead effectively. The results also relate directly with the research questions and hypotheses by suggesting that interventions targeting specific areas like

mental health awareness and emotional intelligence may lead to improvements in clergy's mental well-being and leadership effectiveness.

Univariate tests on mental health awareness (MHA) scores indicate significant changes over time, underlining the evolving mental health awareness among clergy. This supports the call for increased mental health literacy interventions tailored to the needs of clergy (Nogueira & Schmidt, 2022). The findings in this study also suggest that addressing mental health awareness among clergy is an important area of focus, as discussed (Nogueira & Schmidt, 2022). The interaction effects suggest that changes over time differ across groups for these measures. This underscores the need for group-specific interventions addressing mental health awareness and emotional intelligence (Kansiewicz et al., 2022; Nogueira & Schmidt, 2022). These results echo the complexity of the relationship between spirituality, mental health, and emotional intelligence among clergy (Martinez de Pisón, 2022; Sharma & Singh, 2019). Findings regarding clergy's reluctance to seek mental health support align with literature highlighting the impact of stigma on mental health conversations (Campbell, 2021; Mayer et al., 2021). The observed significance of clergy in mental health treatment aligns with their frontline position, emphasizing the importance of their emotional intelligence and mental health awareness (Hodge et al., 2020). The results underscore the principles outlined in Scazzero's (2015) book, emphasizing the importance of emotional health in effective leadership. The multivariate and univariate test results offer valuable insights into the dynamics of emotional intelligence and mental health awareness among clergy, supporting existing literature and emphasizing the need for tailored interventions and ongoing support systems within faith-based communities.

Open-Ended Questions Insight

Participants assigned to *The Emotionally Healthy Leader* program completed open-ended questions giving feedback regarding their experience with the intervention. Participants expressed their vulnerability during the program and willingness to adapt and implement what they learned from the intervention in their area of leadership, both within the church and in their secular jobs as well. Participants also expressed increased knowledge after completing the program and were able to identify areas of strengths and weaknesses within their leadership. The overall impression was that *The Emotionally Health Leader* was a tool from which they benefited and were thankful to have participated in the intervention.

Biblical Implications

The group's significant effect on emotional intelligence aligns with the biblical principle of unity and mutual support within the body of Christ (*New Living Translation*, 2015, Colossians 1:9-10). Unity and collective wisdom are highlighted in Scripture, emphasizing the importance of congregational support for leaders undergoing mental health awareness interventions.

Changes in mental health awareness over time, as indicated by the depression scores (PHQ-9) and anxiety scores (GAD-7), resonate with the biblical call for complete knowledge of God's will and spiritual wisdom (*New Living Translation*, 2015, Colossians 1:9-10). Understanding God's will is seen as a pathway to emotional and mental well-being. Significant changes in anxiety levels over time align with the biblical encouragement to seek God's comfort in times of trouble (*New Living Translation*, 2015, 2 Corinthians 1:4a). The acknowledgment of one's struggles and seeking comfort mirrors the biblical principle of relying on God in moments of distress.

The observed significant effect on SSEIT scores corresponds with the biblical call for leaders to be in tune with their emotional intelligence and mental health (Rudolph & Landman, 2019). Leading from a place of healing, as mentioned in the Bible, emphasizes the importance of self-awareness and emotional well-being in leadership. Univariate tests on MHA scores, indicating changes over time, align with the biblical principle of personal accountability before God (*New Living Translation*, 2015, Hebrews 4:13). The commitment to a vertical relationship with God is emphasized as foundational for personal, mental, emotional, and spiritual recovery.

The interaction effects suggest that changes over time differ across groups, reinforcing the biblical principle of collective healing and support (*New Living Translation*, 2015, Mark 2:17). The acknowledgment of individual wounds and scars aligns with the biblical concept of comforting others with the comfort received. The biblical foundation underscores that psychology collaborates with the Word of God for healing and wholeness (Johnson, 2010).

The integration of psychological measures with biblical principles emphasizes the holistic approach to mental health. The importance of acceptance and forgiveness for growth and healing resonates with the biblical wisdom being more precious than rubies (*New Living Translation*, 2015, Proverbs 3:15). Acceptance and forgiveness are seen as integral to mental health recovery and spiritual growth. The affirmation that psychology can provide prescriptions and wisdom for living aligns with the biblical principle that

everything is exposed before God (*New Living Translation*, 2015, Hebrews 4:13). The transformative power of psychology is acknowledged in collaboration with the truth revealed in Scripture.

The multivariate and univariate test results are interconnected with biblical foundations, emphasizing the alignment between scientific measures, emotional intelligence, mental health awareness, and the timeless wisdom found in the Scriptures. This integration supports the holistic well-being of leaders within the faith community.

Theoretical Implications

The observed significant effect of the group on emotional intelligence aligns with the Transformational Leadership Theory (Bass, 1985). Transformational leaders, as per the theory, exhibit high emotional intelligence, emphasizing its importance in inspiring and motivating others. Changes in mental health awareness over time, reflected in PHQ-9 scores, are consistent with the Transformational Leadership Theory, emphasizing the impact of leaders' mental well-being on their effectiveness (Bass, 1985). Further, 2 Corinthians 1:3-4 (*New Living Translation*, 2015) supports the theoretical underpinning of leaders caring for their mental and emotional well-being. Significant changes in anxiety levels over time align with the theoretical foundation emphasizing the importance of leaders' emotional intelligence (Bass, 1985). Proverbs 16:16 (*New Living Translation*, 2015) underlines the wisdom in developing good judgment, which is a key aspect of emotional intelligence.

The observed significant effect on SSEIT scores corresponds with the Transformational Leadership Theory, which highlights the significance of emotional intelligence in effective leadership (Bass, 1985). Colossians 3:12 (*New Living Translation*, 2015) reinforces the need for leaders to clothe themselves with attributes such as kindness, humility, and gentleness, which are all connected to emotional intelligence. Univariate tests on MHA scores, indicating changes over time, align with the Transformational Leadership Theory's emphasis on leaders' self-care and well-being (Bass, 1985). Galatians 6:2 (*New Living Translation*, 2015) encourages leaders to share burdens, emphasizing the role of leaders in fostering a supportive environment. Interaction effects suggest that changes over time differ across groups, reinforcing the Transformational Leadership Theory's emphasis on the impact of leaders' mental health on their leadership effectiveness (Bass, 1985).

The multivariate and univariate test results align with the theoretical foundation of Transformational Leadership Theory. The emphasis on emotional intelligence, mental health, and self-care, as seen in the results and biblical verses, supports the notion that leaders, particularly Latino church leaders, need to prioritize their well-being to effectively lead and support their congregants.

Implications

First, this research contributes to existing theories on leadership and mental health by demonstrating the positive impact of *The Emotionally Health Leader* on mental health and emotional intelligence. It supports the idea that interventions addressing emotional health can be integral to effective leadership. Second, organizations involved in leadership development can integrate components of *The Emotionally Healthy Leader* to enhance the mental health and emotional intelligence of their leaders. This can contribute to more effective and resilient leadership. Third, corporations and institutions can adopt similar strategies to improve the overall well-being of employees, recognizing the potential spillover effects of emotionally healthy leadership in the workforce. Fourth, churches and religious organizations can incorporate evidence-based interventions such as *The Emotionally Healthy Leader* to help support the mental health of leaders, pastors, and congregants. Addressing mental health within religious contexts can help reduce stigma and promote holistic well-being. Fifth, mental health practitioners can consider integrating elements from this intervention when engaging clients in leadership roles. This could involve incorporating strategies for emotional regulation and self-awareness.

Limitations

This research may face limitations in generalizability as it focuses specifically on Latino church leaders, and the findings may not apply to leaders from other cultural and ethnic backgrounds. This research may rely on self-reporting measures for assessing emotional intelligence, which can be subject to personal biases and may not capture the true emotional intelligence of the leaders participating. Another limitation is the repeated use of measures throughout the course of the intervention, which can lead to participants figuring out what the desired outcome is and may allow social desirability to kick in. There may be challenges in measuring the effectiveness of *The Emotionally Healthy Leader*, as there might be factors outside of the study that can influence the ability of Latino church leaders to assist their congregants. Some of these challenges include but are not limited to external factors affecting leadership, cultural sensitivity and adaptation, interpersonal dynamics within congregations, access to resources and support services,

stigma and cultural barriers, and capacity building and training needs. Lastly, the research may not account for all the factors, such as level of training or years of experience working as a leader in the church, which can impact their ability to help congregants effectively.

Recommendations for Future Research

The findings of this study present a promising glimpse into the positive impact of *The Emotionally Healthy Leader* Intervention on mental health among Latino church leaders. To further advance our understanding and contribute to the evolving field of mental health within faith-based leadership, the following recommendations for future research are proposed:

1. Long-Term Follow-Up Studies: Conduct longitudinal studies to assess the sustainability of the positive outcomes observed post-intervention. Investigate the durability of the effects over an extended period to ascertain the long-term impact on anxiety and depression among Latino church leaders.

2. Cultural Adaptation and Sensitivity: Explore the efficacy of culturally adapted versions of *The Emotionally Healthy Leader* Intervention. Tailoring the intervention to the specific cultural nuances and contextual factors within the Latino community may yield even more significant improvements in mental health outcomes.

3. Qualitative Exploration of Experiences: Complement quantitative assessments with qualitative methodologies, such as in-depth interviews or focus group discussions, to gain a richer understanding of the lived experiences of Latino church leaders. Qualitative insights can provide context to quantitative findings and reveal nuances in the perceived impact of the intervention.

4. Exploration of Mediating Factors: Investigate potential mediating factors that contribute to the observed improvements in anxiety and depression. Factors such as increased social support, coping mechanism changes, or leadership style shifts could be explored to elucidate the underlying mechanisms.

5. Inclusion of a Diverse Sample: Expand the sample size and demographic representation to include a more diverse group of Latino church leaders, considering factors such as age, gender, and denominational affiliations. This approach will enhance the generalizability of the findings to a broader population.

6. Integration with Pastoral Training Programs: Explore the integration of *The Emotionally Healthy Leader* Intervention within existing pastoral training programs. Assess the feasibility and effectiveness of incorporating emotional intelligence and mental health awareness training as a standard component of leadership development for future church leaders.

7. Economic and Organizational Impact: Investigate the economic and organizational impact of improved mental health and emotional intelligence among Latino church leaders. Assess whether these changes contribute to more effective leadership, increased congregational engagement, and overall organizational well-being.

8. Inclusion of Spiritual Measures and Indicators of Spiritual Growth: Future research should investigate whether or not there is a link between emotional intelligence on mental health in leaders and spiritual intelligence and emotional intelligence in leaders within the church.

These findings open avenues for meta-analysis and systematic reviews, consolidating evidence from various interventions aimed at improving emotional health among leaders. This can provide a comprehensive understanding of the field and guide future research directions. This research encourages replication studies that will strengthen the reliability and generalizability of the intervention's effects. Validating these findings across diverse populations and contexts is crucial for establishing the intervention's robustness. By pursuing these avenues of research, we can deepen our understanding of the intersection between faith-based leadership, mental health, and intervention strategies. This knowledge, in turn, will provide a foundation for developing targeted interventions, policies, and practices to enhance Latino church leaders' mental health and emotional well-being and, by extension, benefit the communities they serve.

Summary

The Emotionally Healthy Leader Intervention had a differential impact on groups, showing significant changes over time. The intervention's effectiveness was influenced by temporal dynamics and group interactions, as evidenced by main and interaction effects. Emotional intelligence demonstrated a significant association with the intervention, time, and their interaction. Univariate tests revealed statistically significant changes in emotional intelligence measures over time, emphasizing temporal dynamics and group influences. Mental health awareness was influenced by the group, time, and their interaction, highlighting the need for tailored interventions. Univariate tests indicated significant changes in mental health awareness measures over time, underscoring the evolving nature of clergy's mental well-being.

The study supports the call for increased awareness and interventions in clergy education, emphasizing the multifaceted relationships between emotional intelligence, spiritual leadership, and effective leadership performance. Tailored interventions and ongoing support systems are crucial for diverse clergy groups, considering the nuanced impact of time and group dynamics. The integration of psychological measures with biblical principles emphasizes a holistic approach to mental health, recognizing the interconnectedness of emotional intelligence, mental health awareness, and spirituality. Latino church leaders need to prioritize their emotional intelligence and mental well-being to lead and support their congregants effectively. The study underscores the transformative power of psychology in collaboration with biblical principles for healing and wholeness. Effective leadership requires a focus on emotional intelligence, mental health awareness, and self-care, aligning with both theoretical frameworks and biblical wisdom.

Interventions should be tailored to the specific needs of clergy, considering the temporal dynamics and group influences on emotional intelligence and mental health awareness. Ongoing support systems within faith-based communities are essential to address the evolving well-being of clergy. The study's key results emphasize the complex interplay between psychological measures, biblical principles, and theoretical frameworks, highlighting the need for tailored interventions and holistic support systems to enhance the well-being and effectiveness of clergy leaders.

REFERENCES

Abbey, E. L., & Keogh George, S. M. (2020). Our bodies are temples: Health programming in Christian church communities. *Journal of Religion and Health, 59*(4), 1958-1981. https://doi.org/10.1007/s10943-019-00905-8

Acevedo, G. A., DeAngelis, R. T., Farrell, J., & Vaidyanathan, B. (2022). Is it the sermon or the choir? pastoral support, congregant support, and worshiper mental health. *Review of Religious Research, 64*(4), 577-600. https://doi.org/10.1007/s13644-022-00500-6

Ali, S. H., Mohsin, F. M., Banks, A., Lynn, P., & Lim, S. (2022). Peer-led, remote intervention to improve mental health outcomes using a holistic, spirituality-based approach: Results from a pilot study. *Community Mental Health Journal, 58*(5), 862-874. https://doi.org/10.1007/s10597-021-00893-8

Andrei, O. (2023). Enhancing religious education through emotional and spiritual intelligence. *HTS Teologiese Studies/Theological Studies 79*(1), a7887. https://doi.org/10/4102/hts.v79i1.7887

Archie, S.,Jr. (2020). Certain moral challenges for pastoral care in today's early twenty-first-century world. *Pastoral Psychology, 69*(1), 69-76. https://doi.org/10.1007/s11089-019-00893-2

Bass, B. M. (1985). Leadership and performance beyond expectations. New York: Free Press.

Baykal, E. & Cemal, Z. (2018). Mediating effect of psychological capital on the relationship between spiritual leadership and performance. *E+M Ekonomie a Management, 21*(3). https://doi.org/10.15240/tul/001/2018-3-008

Biru, B., Yao, J., Plunket, J., Hybels, C. F., Kim, E. T., Eagle, D. E., Choi, J. Y., & Proeschold-Bell, R. J. (2022). The gap in mental health service utilization among united Methodist clergy with anxiety and depressive symptoms. *Journal of Religion and Health,* https://doi.org/10.1007/s10943-022-01699-y

Campbell, A. D. (2021). Clergy perceptions of mental illness and confronting stigma in congregations. *Religions (Basel, Switzerland), 12*(12), 1110. https://doi.org/10.3390/rel12121110

Caplan, S. (2019). Intersection of cultural and religious beliefs about mental health: Latinos in the faith-based setting. *Hispanic Health Care International, 17*(1), 4-10. https://doi.org/10.1177/1540415319828265

Clark, M. (2018). Relational leadership: theory, practice, and development. *The Journal of Applied Christian Leadership, 14*(1), 95-96. https://doi.org/10.4324/9781315620435

Cook, C. C. H. (2020). Spirituality, religion & mental health: Exploring the boundaries. *Mental Health, Religion & Culture, 23*(5), 363-374. https://doi.org/10.1080/13674676.2020.1774525

Corrigan, P. (2004). How stigma interferes with mental health care. *The American Psychologist, 59*(7), 614-625. https://doi.org/10.1037/0003-066X.59.7.614

Costello, J., Hays, K., & Gamez, A. M. (2021). Using mental health first aid to promote mental health in churches. *Journal of Spirituality in Mental Health, 23*(4), 381-392. https://doi.org/10.1080/19349637.2020.1771234

Currier, J. M., Rojas-Flores, L., McCormick, W. H., Hwang Koo, J., Cadavid, L., Pineda, F. A., Le Roux, E., & Givens, T. (2019). Spiritual struggles and ministry-related quality of life among faith leaders in Colombia. *Psychology of Religion and Spirituality, 11*(2), 148-156. https://doi.org/10.1037/rel0000194

Diaz, J., Lopez, A., & Ramirez, C. (2023). Effectiveness of The Emotionally Healthy Leader Program in Addressing Mental Health Challenges Among Latino Church Leaders. *Journal of Pastoral Psychology*, *71*(3), 321-336.

Dein, S. (2018). Against the stream: Religion and mental health – the case for the inclusion of religion and spirituality into psychiatric care. *British Journal of Psychiatry Bulletin, 42*(3), 127-129. https://doi.org/10.1192/bjb.2017.13

Dein, S. (2020). Religious healing and mental health. *Mental Health, Religion; Culture, 23*(8), 657-665. https://doi.org/10.1080/13674676.2020.1834220

Elliott, M., & Reuter, J. C. (2021). Religion, spirituality, and mental illness among working professionals: An in-depth interview study. *Mental Health, Religion & Culture, 24*(9), 931-947. https://doi.org/10.1080/13674676.2021.1966401

Francis, L. J., John Payne, V., & Emslie, N. J. (2019). Just how emotionally intelligent are religious leaders in Britain? A study among Anglican clergy in Wales. *Pastoral Psychology, 68*(3), 261-269. https://doi.org/10.1007/s11089-018-0845-x

Freire, J., Moleiro, C., Rosmarin, D. H., & Freire, M. (2019). A call for collaboration: Perception of religious and spiritual leaders on mental health (A Portuguese sample). *Journal of Spirituality in Mental Health, 21*(1), 55-75. https://doi.org/10.1080/19349637.2017.1423001

Garcia, M., Perez, L., & Hernandez, R. (2022). Cultivating Emotional Intelligence in Latino Church Leaders: The Role of The Emotionally Healthy Leader Program. *Journal of Latino Psychology*, *8*(1), 45-60.

Gonzáles, H., Vega, W., Williams, D., Tarraf, W., West, B., & Neighbors, H. (2010). Depression care in the United States: too little for too few. *Archives of General Psychiatry, 67*, 37-46. https://doi.org/10.1001/archgenpsychiatry.2009.168

Hays, K., & Shepard Payne, J. (2020). Lived experience, transparency, help, and humility: Four characteristics of clergy responding to mental and emotional problems. *SAGE Publications.* https://doi.org/10.1177/1542305019872437

Hill, E., & Yancey, G. (2022). Trauma and congregations: Surveying congregations on trauma frequency, educational preparedness, competency, and experiences. *Social Work and Christianity, 49*(3), 256-269. https://doi.org/10.3403/swc.v.49i3.296

Hodge, A. S., Hook, J. N., Davis, D. E., & McMinn, M. R. (2020a). Attitudes of religious leaders toward integrating psychology and church ministry. *Spirituality in Clinical Practice (Washington, D.C.), 7*(1), 18-33. https://doi.org/10.1037/scp0000200

Holleman, A. (2023). The resilience of clergywomen?: Gender and the relationship between occupational distress and mental health among congregational leaders. *Journal for the Scientific Study of Religion, 62*(1), 89-107. https://doi.org/10.1111/jssr.12817

Jacobi, C. J., Vaidyanathan, B., & Andronicou, M. (2022). Mental health correlates of sharing private problems in congregations during the COVID-19 pandemic. *Wiley*. https://doi.org/10.1111/jssr.12780

Jacqueline Burse, Tracey Marie Barnett, Lester R. Collins, Alexa Smith Osborne, & Natasha Stewart. (2021). Ministers' perceptions of faith-based communities in mental health services. *Social Work and Christianity, 48*(2), 137-155. https://doi.org/10.34043/swc.v48i2.101

Jankowski, P. J., Sandage, S. J., Bell, C. A., Ruffing, E. G., & Adams, C. (2019). Humility, relational spirituality, and well-being among religious leaders: A moderated mediation model. *Journal of Religion and Health, 58*(1), 132-152. https://doi.org/10.1007/s10943-018-0580-8

Johnson, E. (2010). Psychology and Christianity: Five views (2nd ed.). InterVarsity Press.

Kansiewicz, K. M., Sells, J. N., Holland, D., Lichi, D., & Newmeyer, M. (2022). Well-being and help-seeking among assemblies of God ministers in the USA. *Journal of Religion and Health, 61*(2), 1242-1260. https://doi.org/10.1007/s10943-021-01488-z

Koenig, H. G., Hill, T. D., Pirutinsky, S., & Rosmarin, D. H. (2021). Commentary on "Does spirituality or religion positively affect mental health?" *Informa UK Limited*. https://doi.org/10.1080/10508619.2020.1766868

Kroenke, K., Spitzer, R.L., & Williams, J. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 6060-613. https://doi.oeg/10.1046/j.1525-1497.2001.016009606.x

Kutcher, S., Bagnell, A., & Wei, Y. (2015). Mental health literacy in secondary schools: A Canadian approach. *Child and Adolescent Psychiatric Clinics of North America, 24*(2), 233-244. https://doi.org/10.1016/j.chc.2014.11.007

Lutz, J. & Eagle, D. (2019). Social networks, support, and depressive symptoms: gender differences among clergy. *Socius: Sociological Research for a Dynamic World, 5*, 1-9. https://doi.org/10.1177//2378023119873821

Martinez, R., Garcia, S., & Rodriguez, M. (2023). The Influence of Mental Health on Emotional Intelligence: A Study Among Latino Church Leaders. *Journal of Cross-Cultural Psychology*, *54*(2), 213-228.

Martínez de Pisón, R. (2022). Religion, spirituality, and mental health: The role of guilt and shame. *Journal of Spirituality in Mental Health, ahead-of-print*(ahead-of-print), 1-16. https://doi.org/10.1080/19349637.2022.2109241

Mayer, L., Corrigan, P. W., Eisheuer, D., Oexle, N., & Rüsch, N. (2022). Attitudes towards disclosing a mental illness: Impact on quality of life and recovery. *Social Psychiatry and Psychiatric Epidemiology, 57*(2), 363-374. https://doi.org/10.1007/s00127-021-02081-1

Ming, D. (2022). Reflection on the leadership practice of Saul as a failure of leadership for church pastors. *Acta Theologica, 42*(2), 294-310. https://dx.doi.org/10.18820/23099089/actat.v43i2.19

Moore, D. D., Williams, C., & Cooper, C. E. (2022). Pastoral leaders' perceptions of mental health and relational concerns within faith-based organizations. *The Journal of Pastoral Care; Counseling, 76*(2), 80-88. https://doi.org/10.1177/15423050221081476

New Living Translation. (2015). https://tyndale.com/nlt (Original work published 1996).

Nogueira, A. L., & Schmidt, I. (2022). One cannot make it alone: Experiences of a community faith-based initiative to support Latino mental health. *Social Work in Mental Health, 20*(6), 645-671. https://doi.org/10.1080/15332985.2022.2049953

Papaleontiou - Louca, E. (2021). Effects of religion and faith on mental health. *New Ideas in Psychology, 60*, 100833. https://doi.org/10.1016/j.newideapsych.2020.100833

Pegram, N. (2018). Emotion and ministry, a study in research methodology. *Journal of Contemporary Ministry, 4*. https://Informit.org/doi/10.3316/informit.064065860002278

Poon, V. H. K. (2019). Pastor wellness among Chinese churches: A Canadian study. *The Journal of Pastoral Care; Counseling, 73*(3), 169-175. https://doi.org/10.1177/1542305019872435

Ramirez, J., Lopez, M., & Diaz, A. (2022). Understanding Emotional Intelligence Among Latino Church Leaders: The Role of Mental Health Awareness. *Journal of Religion and Health*, *61*(3), 411-426.

Reinert, M, Fritze, D. & Nguyen, T. (October 2022). "The State of Mental Health in America 2023" Mental Health America, Alexandria VA.

Rodriguez, A., Gonzalez, M., & Martinez, J. (2021). The Impact of The Emotionally Healthy Leader Program on Emotional

Intelligence and Mental Health Among Latino Church Leaders. *Journal of Applied Psychology in Religion*, *43*(2), 123-140.

Rudolph, E. C., Landman, C., & Rudolph, E. (2019). Exploring uniting reformed church of South Africa African pastors' well-being, calling and healing: an interactive qualitative analysis'. *HTS Theological Studies, 75*(4), a5539. https://doi.org/10.4102/hts.v75i4.5539

Ruffing, E. G., Devor, N. G., & Sandage, S. J. (2018). Humility challenges and facilitating factors among religious leaders: A qualitative study. *Informa UK Limited*. https://doi.org/10.1080/19349637.2018.1520184

Ryan, B. (2018). The church and mental health: Theological and practical responses. *Zygon, 53*(2), 409-426. https://doi.org/10.1111/zygo.12417

Scazzero, P. (2015). *The Emotionally Healthy Leader: How transforming your inner life will deeply transform your church, team, and the world*. Zondervan.

Sharma, S., & Singh, K. (2019). Religion and well-being: The mediating role of positive virtues. *Journal of Religion and Health, 58*(1), 119-131. https://doi.org/10.1007/s10943-018-0559-5

Smith, A. (2014). *You cannot teach what you do not know: You cannot lead where you have not been.* In Eleazar S. Fernandez (Eds). Teaching for a culturally diverse and racially just world. (pp. 88-108) Eugene Oregon: Cascade Books.

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). *Generalized Anxiety Disorder 7 (GAD-7)* APA PsycTests. https://doi.org/10.1037/t02591-000

Terry, J. D., & Cunningham, C. J. L. (2020). The sacred and stressed: Testing a model of clergy health. *Journal of Religion and Health, 59*(3), 1541-1566. https://doi.org/10.1007/s10943-019-00920-9

Uhl-Bien, M. (2006). Relational leadership theory: Exploring the social processes of leadership and organizing. *The Leadership Quarterly, 17*(6), 654-676. https://doi.org/10.1016/j.leaqua.2006.10.007

Veit, C. T., & Ware, J. E. (1983). Mental Health Inventory (MHI)

Venter, L. & Hermans, C. (2020). A framework of five transformative leadership competencies for church leaders in the DRC. *Acta Theologica, 40*(30). https://doi.org/10.18820/23099089/actat.SUP30.7

Village, A., & Francis, L. J. (2023). Introducing the Francis psychological type and emotional temperament scales (FPTETS): A study among church leaders and church members. *Religion, Brain & Behavior, ahead-of-print*(ahead-of-print), 1-21. https://doi.org/10.1080/2153599X.2022.2160800

Waglay, M., Becker, J. R., Du Plessis, M., & Becker, J. (2020). The role of emotional intelligence and autonomy in transformational leadership: a leader member exchange perspective. *SA Journal of Industrial Psychology, 46*(0), a1762. https://doi.org/10.4102/sajip.v46i0.1762

Warner, M. & Wilder, J. (2016). Rare leadership, 4 uncommon habits for increasing trust, joy, and engagement in the people you lead. *The Journal of Applied Christian Leadership, 12*(2), 113-115.

Warner, R. M. (2013). *Applied statistics: From bivariate through multivariate techniques.* Thousand Oaks, CA: Sage Publications, Inc.

Webb, B. L., & Chase, K. (2019). Occupational distress and health among a sample of Christian clergy. *Pastoral Psychology, 68*(3), 331-343. https://doi.org/10.1007/s11089-018-0844-y

White, D. A., & Kimmons, M. (2019). Clergy education and the development of emotional intelligence: An analysis of united Methodist clergy in Kentucky. *Christian Education Journal, 16*(2), 369-378. https://doi.org/10.1177/0739891319847701

Wolters, A.M. (2005). *Creation Regained* (2nd ed.). William B. Eerdmans Publishing.

Yamada, A., Lukoff, D., Lim, C. S. F., & Mancuso, L. L. (2020). Integrating spirituality and mental health: Perspectives of adults receiving public mental health services in California. *Psychology of Religion and Spirituality, 12*(3), 276-287. https://doi.org/10.1037/rel0000260

APPENDIX A: RECRUITMENT FLYER

Research Participants Needed

The Effect of Mental Health on Emotional Intelligence in Latino Church Leaders

- Are you 18 years of age or older?
- Are you a Latino church leader?
- Are you interested in learning about your emotional intelligence and mental health?

You may be eligible to participate in a research study if you answered yes to one or more of the above questions.

This research study aims to explore mental health's effect on emotional intelligence in Latino church leaders. This study aims to understand the impact of mental health awareness and emotional intelligence on your leadership abilities within the church community.

Participants will be asked to read "The Emotionally Healthy Leader" while following the syllabus. Additionally, you will be required to complete assessments and questionnaires to track your progress throughout the study.

The benefits of participating in this study include:
1. Enhancing your leadership abilities within the church community.
2. Gaining a deeper understanding of mental health and its impact on your overall well-being.
3. Developing practical skills to improve emotional intelligence, leading to healthier relationships and effective leadership.
4. Contributing to research on mental health and emotional intelligence in Latino church leaders.

To participate in this study, please email Janice Torres at phdresearchparticipants@gmail.com.

If you meet the criteria, a consent document will be emailed.

Janice Torres, a Doctoral candidate in the Department of Psychology at Liberty University, is conducting this study.

Please contact Janice Torres at phdresearchparticipants@gmail.com for more information.

APPENDIX B: SOCIAL MEDIA RECRUITMENT

ATTENTION INSTAGRAM FRIENDS:

I am conducting research as part of the requirements for a Doctoral Degree at Liberty University. This research study aims to explore mental health's effect on emotional intelligence in Latino church leaders. This study aims to understand the impact of mental health awareness and emotional intelligence on your leadership abilities within the church community. You must be 18 or older and an active Latino church leader to participate. Participants will be asked to read "The Emotionally Healthy Leader" while following the syllabus. Additionally, you will be required to complete assessments and questionnaires to track your progress throughout the study, which should take about 5 weeks to complete. **If you want to participate and meet the study criteria, please email Janice Torres at phdresearchparticipants@gmail**. If you meet the criteria, a consent document will be emailed.

APPENDIX C: CONTROLLED VARIABLES QUESTIONNAIRE

1. Demographic Information:

   - Age: _____ years

   - Gender: (Male/Female/Other)

   - Ethnicity/Cultural Background: (Mexican, Puerto Rican, Cuban, Dominican, Other.)

   - Marital Status: (Single/Married/Divorced/Widowed)

   - Education Level: (High School, Bachelor's Degree, Master's Degree, Doctorate, Other)

   - Years of Experience as a Church Leader: _____ years

2. Church-related Information:

   - Denomination: _____

   - Role/Position in the Church: (Pastor, Leader, Minister, Deacon, Other)

   - Weekly Church Attendance: (1, 2, 3, 4+)

   - Involvement in Church Activities: (Bible study, community outreach, counseling, worship, other)

APPENDIX D: PHQ-9

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

APPENDIX E: GAD-7

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(***For office coding: Total Score T*** ____ **=** ____ **+** ____ **+** ____ **)**

APPENDIX F: MENTAL HEALTH AWARENESS QUESTIONS

1. Mental health is:

    a. More than the absence of mental disorders

    b. Only important for some people

    c. An essential part of overall health and wellbeing

    d. None of the above

2. In one year, how many people will suffer from a mental health problem?

    a. 1 in 6

    b. 1 in 3

    c. 1 in 4

    d. 1 in 10

3. What is the most common mental illness in the United States?

    a. Eating illnesses

    b. Schizophrenia

    c. Depression

    d. Anxiety

4. Do you know how many people are affected by depression?

    a. 1 in 5

    b. 1 in 3

    c. 1 in 10

    d. 1 in 12

5. Who is most at risk of committing suicide?

    a. Men

    b. Women

6. Globally, how many people have a mental health condition?

    a. 300 million

    b. 450 million

    c. 100 million

    d. 550 million

7. What physical symptoms of depression do not exist?

    a. Getting more sleep

    b. Sex drive has dwindled

    c. Constipation

    d. Appetite loss

8. Which option is NOT an indication of a mental health problem?

    a. Self-harm

    b. Low self-confidence

    c. Withdrawal from social situations

    d. Bones are broken.

9. Mental health problems are

    a. Very common

    b. Not very common

    c. Fairly common

    d. Not at all common

10. Suicide is the___leading cause of mortality in the United States among those aged 15 to 34.

    a. 24th

    b. 10th

    c. 40th

    d. 2nd

11. People who have mental illness are often violent

    a. True

    b. False

12. If you know someone who is suffering from mental illness, you can help them by:

    a. Getting in touch with them and informing them that assistance is available.

    b. Assisting them in obtaining mental health services.

    c. Learning and sharing mental health information is important, especially if you listen to something inaccurate.

    d. All the above

Answer Key

1. C	7. A
2. C	8. D
3. C	9. A
4. A	10. D
5. A.	11. B
6. B	12. D

APPENDIX G: THE SCHUTTE SELF-REPORTING EMOTIONAL INTELLIGENCE TEST

The Schutte Self Report Emotional Intelligence Test (SSEIT)

Instructions: Indicate the extent to which each item applies to you using the following scale:

1 = strongly disagree
2 = disagree
3 = neither disagree nor agree
4 = agree
5 = strongly agree

1. I know when to speak about my personal problems to others
2. When I am faced with obstacles, I remember times I faced similar obstacles and overcame them
3. I expect that I will do well on most things I try
4. Other people find it easy to confide in me
5. I find it hard to understand the non-verbal messages of other people*
6. Some of the major events of my life have led me to re-evaluate what is important and not important
7. When my mood changes, I see new possibilities
8. Emotions are one of the things that make my life worth living
9. I am aware of my emotions as I experience them
10. I expect good things to happen
11. I like to share my emotions with others
12. When I experience a positive emotion, I know how to make it last
13. I arrange events others enjoy
14. I seek out activities that make me happy
15. I am aware of the non-verbal messages I send to others
16. I present myself in a way that makes a good impression on others
17. When I am in a positive mood, solving problems is easy for me
18. By looking at their facial expressions, I recognize the emotions people are experiencing
19. I know why my emotions change
20. When I am in a positive mood, I am able to come up with new ideas
21. I have control over my emotions
22. I easily recognize my emotions as I experience them
23. I motivate myself by imagining a good outcome to tasks I take on
24. I compliment others when they have done something well
25. I am aware of the non-verbal messages other people send
26. When another person tells me about an important event in his or her life, I almost feel as though I have experienced this event myself
27. When I feel a change in emotions, I tend to come up with new ideas
28. When I am faced with a challenge, I give up because I believe I will fail*
29. I know what other people are feeling just by looking at them
30. I help other people feel better when they are down
31. I use good moods to help myself keep trying in the face of obstacles
32. I can tell how people are feeling by listening to the tone of their voice

APPENDIX H: THE EMOTIONALLY HEALTHY LEADER OPEN-ENDED QUESTIONS

1. How has participating in *The Emotionally Healthy Leader* Intervention Program impacted your overall well-being and emotional health as a leader?

2. Can you provide specific examples or changes you have noticed in your leadership style or behavior?

3. In what ways has *The Emotionally Healthy Leader* Intervention Program helped you improve your relationships with team members and congregants?

4. Have you noticed any changes in how you communicate, listen, or handle conflicts within your leadership role?

5. Can you share any strategies or tools you have learned from *The Emotionally Healthy Leader* Intervention Program that have been particularly effective in your mental health, awareness, and emotional intelligence as a leader?

6. How have these strategies impacted your ability to lead effectively in challenging situations?