

CONSERVATIVE HOLINESS PASTORS' ABILITY TO ASSESS  
DEPRESSION AND THEIR WILLINGNESS TO REFER TO  
MENTAL HEALTH PROFESSIONALS

by

Andrew James Graham

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

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Faculty of Liberty University  
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Dissertation Committee Approval:

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Chair, John C. Thomas, Ph.D., Ph.D.                      Date

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Fernando Garzon, Psy.D.                                      Date

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Clay Peters, Ed.D.    Date

## ABSTRACT

### CONSERVATIVE HOLINESS PASTORS' ABILITY TO ASSESS DEPRESSION AND THEIR WILLINGNESS TO REFER TO MENTAL HEALTH PROFESSIONALS

Andrew James Graham

Center for Counseling and Family Studies

Liberty University, Lynchburg, Virginia

Doctor of Philosophy in Counseling

The purpose of this study was to investigate the willingness and ability of Conservative Holiness pastors to assess depression and their willingness to refer to mental health professionals. Eighty-six pastors completed a four-part survey that measured diagnostic accuracy, willingness to refer, attitudes toward mental health, perceived competency to assist, recognition of need for help and confidence in mental health professionals.

Demographic characteristics and case study responses were investigated through analysis of frequency data; relationships with demographic variables were analyzed using Spearman's rho and independent t-tests; relationships with variables derived from the scales were analyzed using Pearson Product-Moment Correlation. Analyses found that Conservative Holiness Pastors are willing and able to assess depression and are willing to

refer to mental health professionals. Willingness to refer was associated with positive attitudes toward mental health.

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I am thankful to my parents who instilled within me faith in God – for I have completed this study “through Christ who strengthens me” (Philippians 4:13).

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## CHAPTER ONE: INTRODUCTION

Religious persons identify that they desire that their religion and spirituality be considered in their over-all health care (King & Bushwisk, 1994; Maugans & Wadland, 1991; Pargament, Koenig, Tarakeshwar, & Hahn, 2001) and report that when that integration occurs, they progress better (Koenig, George, & Titus, 2004). Pastors have long been considered a front-line provider of dealing with emotional distress (Oppenheimer, Flannelly, & Weaver, 2004; Wang, Berglund & Kessler, 2003; Weaver, 1995). Approximately 39% of those who acknowledge an emotional problem report consulting a pastor (Kulka, Veroff, & Douvan, 1979). Religious persons identify that they would be more likely to seek help from friends and pastors than from mental health professionals (Morgan, 1982). Milstein (2003) noted that this was not because individuals were unaware of local mental health care resources.

Studies have proposed a number of reasons why people could seek counsel from their pastor (Abramczyk, 1981; Brushwyler, Fancher, Geoly, Matthews, & Stone, 1999; Clemens, Corradi, & Wasman, 1978; Henderson, 1990). It may be that they have a greater level of both comfort and trust since they believe that they have shared values (Abramczyk, 1981; Henderson, 1990). It may be that they perceive it as more socially acceptable to seek counsel from a pastor than from a mental health professional (Clemens et al., 1978). Another key factor may be that due to the costs associated with receiving

professional mental health services, they turn to pastors because their counsel is typically free (Brushwyler et al., 1999).

### **Background of the Problem**

Pastors have many responsibilities and often are called upon to fill such roles as “preacher, teacher, musician, administrator, and counselor” (Peters, 1999, p. 4). Yet, they regard their role to include care and guidance for mental health issues (Benner, 1988; Gilbert, 1981; Larson, 1964) and express concern about passing off pastoral care responsibilities to those under authority of state licensing boards rather than church leaders (Powlison, 2000, 2001). They are most confident addressing issues related to spiritual and moral issues, marriage and family issues, life adjustment issues, and emotional issues and least confident in addressing issues related to severe mental illness (Mannon & Crawford, 1996). Many pastors indicate that lack of time has impacted their ability to function in each of these roles (Ellison & Mattila, 1983; Warner & Carter, 1984). Other pastors are cautious about seeing parishioners for help with mental health issues due to dynamics related to friendship or the parishioner’s role within the church (Krebs, 1980).

Pastors often report not being adequately prepared to handle this important ministry role (Abramczyk, 1981; Buikema, 2001; Burgess, 1998; Farrell & Goebert, 2008; Franklin, 1983; Lunn, 1980; Mannon & Crawford, 1996; Virkler, 1979, 1980; Weaver, 1995; Wylie, 1984). Specifically, pastors identify concerns related to their own expertise in counseling (Virkler, 1979) and recognize that they are often called upon to

face problems beyond their training and level of competence (Lee, 1976). This may be because the training of pastors does not always emphasize counseling (Linebaugh, 1981; Weaver, 1995). In one study, nearly all of the 2,000 pastors surveyed stated that they would benefit from additional counseling training (Weaver, Flannelly, Larson, Stepleton, & Koenig, 2002).

Indications are that the collaboration between pastors and mental health professions occurs more now than in the past (Beck, 2002; Bland, 2003; Burgess, 1998; Edwards, Lim, McMinn, & Dominguez, 1999; McMinn, Chaddock, Edwards, Lim, & Campbell, 1998; McMinn, Meek, Canning, & Pozzi, 2001) yet there still remains a hesitancy for pastors to refer to mental health professionals (Gardner, 2013; Gilbert, 1981; Meylink & Gorsuch, 1998). Only about 10% of those who sought help from pastors were referred on to other providers (Lowe, 1986; Meylink & Gorsuch, 1988). This is of particular concern since pastors have been demonstrated to be no more skilled than lay people at assessing suicidality and psychopathology (Domino, 1985; 1990).

One body of research has emphasized the benefits of counseling by a pastor (Abramczyk, 1981; Beck, 1997; Brushwyler et al., 1999; Clemens et al., 1978; Henderson, 1990) and the complications (Haug, 1999; Miller & Atkinson, 1988; Montgomery and Debell, 1997). A second prominent research direction has related to the beliefs of pastors concerning mental health issues (Holden, Watts & Williams, 1991) and their level of confidence (Burgess, 1998; Eliason, 2000; Watson, 1992). Another direction has been to focus on referral patterns and how they relate to perceived value of professional mental health services (Azlin, 1993; Peters, 1999; Smith, 1999), to doctrinal

and theological positions (Fulz, 2002; Lamberton, 1992; McMinn, Ruiz, Marx, Wright, & Gilbert, 2006; McMinn, 2009; Peters, 1999; Smith, 1999; Wright, 1984), to the amount of training received in counseling (Meylink & Gorsuch, 1988; Peters, 1999) and perceived level of counseling competence by the pastor (Azlin, 1993; Mannon & Crawford, 1996).

Payne (2009) has noted that little research has been conducted to assess views of pastors as they specifically relate to depression. This dynamic has been confounded by the fact that some define “depression to refer to subjective states, whereas clinicians view depression as a state, trait, or symptom, as well as a pathological entity in its own right” (Furnham & Kuyken, 1991 in Trice & Bjorck, 2006, p. 283).

In a landmark study, Larson (1967) noted a number of variables significantly influenced the opinions of pastors related to mental illness including depression; these variables included age, size of the congregation, father’s occupation and education, the pastor’s education, college major, pastoral counseling training, and the number of emotionally distressed persons seen. Differences were also identified based upon denominational affiliation.

Tension has been indicated most frequently between mental health professionals and evangelical pastors (Beck, 2006a; Beck, 2006b; Ellens & Sanders, 2006; Foster & Ledbetter, 1987). Conservative pastors often view counseling as the responsibility and role of the pastor (Benner, 1988; Gilbert, 1981; Larson, 1964) and are more likely to attempt to counsel those with mental health issues without considering referral (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000). They place a lower value on counseling

when compared to their more liberal colleagues (Cumming & Harrington, 1963). In the rare instances when they do refer, conservative pastors express more concern about the religious background of the mental health professional than more liberal pastors (Wright, 1984).

### **Statement of the Problem**

One group of pastors that has not yet been investigated is those who identify with the Conservative Holiness Movement (CHM). Current literature provides data and reflection on issues related to mental health for more mainstream Wesleyans (see Perryman, 1988) and for Fundamentalist Baptists (see Vespie, 2010). A gap exists related to the Conservative Holiness Movement, a collection of pastors and churches that share doctrinal agreement with one group, while sharing the practice of separation (Glick, 2002) with the other. Studying their diagnostic accuracy as it relates to depression and their willingness to refer to mental health professionals may shed light upon the variables related to all pastors.

### **Purpose of the Study**

The purpose of this study is to examine Conservative Holiness pastors' ability to assess for depression and their willingness to refer to mental health professionals. First, the research will assess their diagnostic accuracy using a collection of case studies. Second, their willingness to refer to mental health professionals will be explored.

## **Research Questions**

To explore the perceptions of Conservative Holiness pastors on depression, the following research questions were developed.

1. Are Conservative Holiness pastors willing and able to assess depression in their parishioners?
2. What are the factors that are associated with Conservative Holiness pastors' willingness to consider referral to mental health professionals?

## **Definition of Terms**

In order to properly address the proposed research questions, it is first necessary to clearly define the terms as operationalized in this dissertation. Terms have been divided into two sections: Part one provides definitions for general terminology while Part two provides conceptual meanings for the specific variables.

### **Relevant Terminology**

**Conservative Holiness Movement.** The CHM is a “group of denominations and independent churches... that hold to a core system of doctrinal and lifestyle beliefs” (Oliver, 2011). As noted by Oliver (2011), *holiness* refers to “the belief in entire sanctification, the Wesleyan doctrine of cleansing from inbred sin as a second work of grace after conversion” while *conservative* refers to “the movement’s emphasis on traditional moral values, including simplicity of dress and lifestyle” (para. 1).

**Depression.** The criterion for depression as listed in the Diagnostic and Statistical Manual, IV-TR (APA, 2000):

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

(4) Insomnia or hypersomnia nearly every day

(5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) Fatigue or loss of energy nearly every day

(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation (p. 356).

**Pastor.** As different churches and denominations conceptualize the role of pastor differently, the operational definition for this study was the ordained minister with authority to oversee the operations and ministries of a local body of believers.

Interchangeable terms include clergy, minister, preacher, and others.

**Physician.** A physician's duties are to "diagnose and treat injuries and illnesses in patients" (Physicians and Surgeons, 2010-2011, para. 1).

**Pastoral Counseling.** Pastoral counseling can be done by a pastor or lay leader. It is a "time-limited relationship that is structured to provide comfort for troubled persons by enhancing their awareness of God's grace and faithful presence and thereby increasing their ability to live their lives more fully in the light of these realizations" (Benner, 2003, p. 40)

**Mental Health Professional.** Mental health professionals "help people to manage or overcome mental and emotional disorders and problems with their family and relationships" (Mental Health Counselors and Marriage and Family Therapists, 2010-2011, para. 1). This designation applies to the following professions: psychiatrist,

psychologist, clinical social worker, psychiatric nurse, marriage and family therapist, and licensed professional counselor (Grohol, 2006).

### **Variables in the Study**

This study includes predictor variables and outcome variables, also known as independent and dependent variables. The determination of variables is based upon both the theory and research of other investigators and upon personal hypotheses having conversed with CHM pastors related to depression.

**Outcome Measures.** The first outcome measure is the Conservative Holiness pastor's ability to assess depression. The second outcome measure is the Conservative Holiness pastor's willingness to refer to a mental health professional. This study will investigate which variables are associated with those decisions.

**Predictor Measures.** The pastor's perception of depression and mental health treatment is one major predictor variable composed of the following constructs:

- **Attitudes toward Mental Health** – the pastor's perceptions as to whether professional mental health counseling is appropriate and effective in treating depression.
- **Perceived Competency** – the pastor's perceptions as to the ability to adequately help those struggling with depression.

- **Recognition of the Need for Help** – the pastor’s perceptions as to the necessity and value of professional counseling.
- **Confidence in Mental Health professionals** – the pastor’s perceptions as to the treatment efficacy of professional counseling.

**Demographic Predictors.** Demographic variables are descriptive in nature but remain vital to analysis as they provide a profile of the study participants. This profile will also assist in contextualizing the outcome measures of this study.

- **Gender** – biological sex of the pastor: Male or Female
- **Age** – biological age of the pastor: under 25 years of age, 26-40 years of age, 41-55 years of age, 56-70 years of age, over 71 years of age.
- **Race** – race of the pastor: White or Other.
- **Marital status** – marital status of the pastor: Never Married, Married, Separated, Divorced, Widowed.
- **Education** – the educational achievements of the pastor: High School, Some College, Bachelor’s degree, Some Graduate work, Graduate degree.
- **College** – the college where the pastor received undergraduate training: Alleghany Wesleyan College, God’s Bible School, Hobe Sound Bible College, Penn View Bible Institute, Union Bible College, or other.
- **Counseling Training** – the amount of counseling-specific training received by the pastor: no course, 1 course, 2-3 courses, 4-5 courses, 6 or more courses.

- **Pastoral Ministry** – the total years of pastoral ministry for the pastor: under 5 years, 6-20 years, 21-35 years, 36-50 years, over 51 years.
- **Denomination** – the identified denomination of the pastor and the identified denomination of the church.
- **Size of Church** – the attendance for Sunday morning services of the church where the pastor currently serves: under 20 attendees, 21-40 attendees, 41-60 attendees, 61-80 attendees, over 80 attendees.

### **Assumptions and Delimitations**

It is important to note that the ability to assess depression is far more complex than can possibly be contextualized in a limited set of vignettes. It is assumed that a pastor's view would change depending on the circumstances; other vignettes may provide different results.

Each instrument used in this study is a self-report measure. While not privy to the entire scope of the study, participants were made aware that their views of depression were being assessed. A desire to demonstrate competency may have contributed to bias. The assumption was that participants would respond honestly to each item. As a means of reducing the possibility of dishonest responses, informed consent was reviewed with each participant and issues related to confidentiality were discussed to ensure and document the security of their anonymity.

A delimitation is that this study was limited to Conservative Holiness pastors who were in attendance at the 2012 Interchurch Holiness Convention. While those who attend vary in denominational structure and region, they may not be representative of all CHM pastors.

While this investigator is not a member of a CHM church, an identification with the Conservative Holiness Movement is present. The author is a graduate of a CHM Bible college, is on the board of directors for that CHM college, and has consulted with a number of CHM pastors and churches on topics and situations related to mental health issues.

### **Significance of Study**

The purpose of this study is to add to the current research on the views of pastors towards depression, its diagnosis and treatment, and referral options. For many, pastors serve as primary sources of counsel, including on matters related to mental illness (Mannon & Crawford, 1996). Previous studies have noted that conservative pastors have a low opinion of mental health distress (Larson, 1967) and a low value of professional counseling (Cumming & Harrington, 1963). A review of the literature will identify a gap in the knowledge of those pastors who are conservative in their interpretation of Scripture, yet Wesleyan in theological orientation. This study seeks to address that gap.

## **Chapter Summary**

Christians often turn to their pastor for direction related to depression. The ability to assess for depression and the willingness to refer to mental health professionals will be the focus of this investigation. Pastors who identify with the Conservative Holiness Movement will be the target population. This investigation can make inferences regarding the need for further training in these areas.

## **Organization of Chapters**

Chapter Two reviews the current information related to pastoral views on depression and other corresponding mental health concerns. It notes the long-standing role of pastoral counseling, the onset of conflict between the fields of psychology and Christianity, and contemporary perspectives on each sphere.

Chapter Three further describes the study population, procedures, instruments inclusion and exclusion criteria, analysis of the data, and ethical considerations. It reviews the research questions and describes the methodology used to analyze the pastor's ability to assess depression and willingness to refer to mental health professionals.

Chapter Four provides the results of the statistical analysis and reflections on each research question. Chapter Five includes interpretations of these findings, reviews study limitations, and discusses implications for current action as well as future research.

## CHAPTER TWO: LITERATURE REVIEW

This chapter will review the literature on the Conservative Holiness Movement, depression in contemporary culture and the church, and the role of pastors in counseling and referral for depression. Throughout this chapter, the term pastor will be used where literature may use synonyms such as minister, preacher, or other terms to describe members of the clergy. The term mental health professional will be used where literature may use discipline-specific terms such as psychologist, psychiatrist, clinical social worker, psychiatric nurse, marriage and family therapist, licensed professional counselor or other terms to describe those providing professional mental health treatment.

### **The Conservative Holiness Movement**

The Conservative Holiness Movement (CHM) involves a total of 3,000 churches and as many as 100,000 parishioners (Black, 2003). Accurate statistical information is difficult to obtain as the CHM is not a denomination but rather a collection of regional denominational groups and independent churches (Black, 2003). This dynamic may contribute to the fact that the CHM “receives thin treatment from historians” despite its growth since its development in the second half of the 20th century (Sidwell, 1999).

The Conservative Holiness Movement is Wesleyan-Arminian in theological orientation (Thornton, 1998). Those who self-identify as CHM ascribe to evangelical Christianity with a historic Methodist message (Black, 2003). Distinctive doctrines of

Wesleyan heritage include “justification by faith, the witness of the Spirit, and Christian perfection” (Hotle, 1991, p. 118). There is, however, a “wide divergence among those who claim to be disciples of Wesley” (Thornton, 1998, p. 26) due largely to significant shifts in the lifestyle standards of Wesleyan believers during the nineteenth and twentieth centuries (England, 1998).

By the middle of the 20th century, collections of churches had left traditional Wesleyan-Arminian denominations – including the Church of the Nazarene, the Church of God (Anderson), the Wesleyan Methodist Church, the Pilgrim Holiness Church, and the Free Methodist Church (Thornton, 1998) – out of a desire to “take a strong stand against centralized government, merger, worldliness (rings, television, bobbed hair, immodest attire, etc.) and the degenerating spiritual conditions in denominational schools” (Schmul, Fruin, Sankey & Rundell, 1987, p. 5). After a period of division from larger denominations in the 1950s and 1960s, there became a consolidation of groups during the 1970s and 1980s as independent churches and regional denominations began to form a common identity (Thornton, 1998).

Early unification of churches began with the formation of what became the Interchurch Holiness Convention (IHC) in 1951. Church leaders were sent an invitation that expressed the objectives of the new gathering:

Because of the moral corruption nationally and internationally; because of the lethargy of the Church world; because the Holiness movement is losing her identity and distinguishing doctrine of Holiness; because much of the ministry is neglecting the unpopular Bible themes on Holiness, adornment and separation from the world, we call this convention for fasting, prayer, humiliation and heart searching, that the Holy Spirit may visit us again with old-time power. (as cited in Kostlevy, 2009, p. 160)

IHC, a three-day long convention, provided a “channel of fellowship and cooperation” in which “various groups step across denominational lines for fellowship, cooperative worship, sharing a common task together” (Herron, 1987, p. 50). In his *Chronology of Significant Events*, Thornton (1998) lists the formation of the IHC in 1951 as the “birth date” of the Conservative Holiness Movement, noting that IHC “has united the conservative holiness people as no other instrument” (p. 157). The IHC now averages attendance of 6,000 while continuing to operate with the same commitments that led to its development in 1951 when 200 responded to the invitation above (Kostlevy, 2009).

The Conservative Holiness Movement is often linked with Protestant Fundamentalism (Sidwell, 1999). More mainstream denominations that identify themselves as Wesleyan reject the notion that they have shared characteristics (Stanley, 1998). However, in each of the areas in which Stanley (1998) notes conflicts between Wesleyans and Fundamentalists – the inerrancy of Scripture, premillennialism, and social holiness – the CHM would often side with Fundamentalists (see Melton & Sauer, 1988; Trouten, 1978). The primary distinctive of Fundamentalism: separation from the world, from false doctrines, from other ecclesiastical connections (Sidwell, 1998), is also a primary distinctive within the CHM as well, though generally the CHM stresses separation of practice rather than separation over doctrine (Hallaway, 1987).

The differences between Wesleyan statements of belief and the Five Fundamentals are significant in both content and concern (Crawford, 2002). Theological differences are substantial, not only on the issue relates to a second-work of grace but particularly in perspectives on the methodology used for establishing theological

positions. Outler (1964) coined the phrase *Wesleyan Quadrilateral* to conceptualize Wesley's four-fold approach to drawing conclusions: Scripture, tradition, reason, and experience. CHM leaders endorse this perspective (Brown, 1995) – a perspective that has been noted to be a viable model for the integration of psychology and theology (Porter, 2004). As a result, adherents prefer the term “conservative” over “Fundamentalist” (Dayton, 1975).

### **Depression**

Depression has been referred to as “the common cold of mental illnesses” (Rosenhan & Seligman, 1995, p. 307). Major Depressive Disorder, one of several mood disorders categorized in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), is the most frequently diagnosed psychiatric disorder for adults in the United States (Craighead, Hart, Craighead, & Illardi, 2002).

### **Diagnosis**

It is important to distinguish depression from bad moods or grief; depression of a clinical nature interferes with daily functioning and relationships (Lastoria, 1999). Major Depression is defined by the American Psychiatric Association (2000) as:

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

- (1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.
- (2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
- (3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
- (4) Insomnia or hypersomnia nearly every day
- (5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
- (6) Fatigue or loss of energy nearly every day
- (7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- (8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
- (9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

Valid screening tools include the Beck Inventory for Measuring Depression (Beck, 1967) and the Zung Self-Rating Depression Scale (Zung, 1973) though diagnosis should be provided only by a trained professional. While many with depression are able to live high-functioning lives, others have significant impairment (Seligman & Reichenberg, 2007).

## **Prevalence**

The National Institutes of Mental Health speculates that depression affects more than eighteen million adults in the United States in a given year (NIMH, 2003). During their lifetime, one out of every five women and one out of every eight men suffer from depression (Kessler, 1994). Yet, 25% of those who meet criteria for a mental health disorder do not seek out treatment of any kind (Brown & Bradley, 2002) in part because it remains a stigmatized condition among the general public (Berkins, Petch, & Atkinson, 2003; Corrigan & Penn, 1999).

It has been estimated that among mental health disorders, depression will become the second leading cause of disability by 2020 (Michaud, Murray, & Bloom, 2001). The prevalence is increasing and occurring at younger and younger ages (Somerset, Newport, Ragan, & Stowe, 2006). Despite comprehensive campaigns orchestrated to address stigma and promote the seeking of treatment (Corrigan et al., 1999), obstacles remain in place (Goldney, Fisher, Wilson, & Cheok, 2002; Lauber, Nordt, Falcato, & Rossler, 2004).

## **Etiology**

There are a number of theories that attempt to conceptualize how biology, early family interaction, learning and cognition and social environment interact to produce depression; the most popular theories are psychodynamic, behavioral, cognitive, systemic, and biological (Lastoria, 1999). Kessler (2006) found that depression often follows a traumatic life event or loss. Stressors may also include disruption in

relationships or career disappointments (Whisman, Weinstock, & Tolejko, 2006).

Genetic components seem to be at work as depression has been linked to a family history of depression (Goodman & Tully, 2006), anxiety or other psychological disorders (Kessler, 2006). The respective theories each view depression through a different lens.

While each theory has its own empirical evidence, no one theory entirely accounts for all dynamics. As such, most hold to a biopsychosocial theory of depression acknowledging the role of biological, psychological, and social factors (Lastoria, 1999).

## **Treatment**

The treatment options available for depression reflect the variety of theoretical conceptualizations and correspond to the respective treatment providers.

**Physicians.** Physicians and psychiatrists are able to prescribe medications for those diagnosed with a depressive disorder. The three main categories of medications used for depression are tricyclics that increase the availability of norepinephrine and serotonin to the brain, monoamine oxidase inhibitors that increase norepinephrine and dopamine, and selective serotonin reuptake inhibitors that increase serotonin (Seligman & Reichenberg, 2007). Each of the three medication options is effective and none is habit-forming; the differences between them are primarily related to side effects (Lastoria, 1999).

**Mental Health Professional.** Mental health counseling is an effective treatment for depression that is not confounded by mania, psychosis, cognitive impairment or substance abuse (Young, Weinberger, & Beck, 2001). After one or two months of

appropriate treatment, 80% of depressed individuals report feeling better (Reid, 1997).

The National Institute of Mental Health has indicated that more important than the specific therapeutic orientation is the therapeutic alliance between the mental health professional and client (Krupnick et al., 1996). Yet Seligman and Reichenberg (2007) note that empirical research points toward the efficacy of two specific counseling strategies in the treatment of depression: cognitive-behavioral therapy and interpersonal therapy.

Cognitive-behavioral therapy (CBT) is as effective as both tricyclic antidepressants and monoamine oxidase inhibitors (Craighead, Miklowitz, Frank, & Vaik, 2002). It has been particularly effective with young people (Kaslow & Thompson, 1998; Reinecke, Ryan, & DuBois, 1998). The cognitive-behavioral approaches are effective because:

They present a concrete rationale for depression and treatment, as well as a vocabulary for defining and describing the problem. They educate clients about the relationship between thoughts and feelings and teach self-monitoring skills for dysfunctional thoughts. They are highly structured and offer clear plans for change, giving people a sense of control. They provide feedback and support so that people can see change, receive reinforcement, and attribute improvement to their own efforts. They teach skills that increase personal effectiveness and independence. They include relapse prevention strategies. (Seligman and Reichenberg, 2007, p. 190)

Interpersonal Psychotherapy (IPT) also has been empirically validated for the treatment of depression (Craighead, Hart et al., 2002) and has been found to be as effective as antidepressants in some situations (Hollon, 2000). IPT views depression components as symptom function, social and interpersonal relations, and personality and character problems (Mufson, Dorta, Moreau, & Weissman, 2004). The key areas are

abnormal grief, nonreciprocal role expectations in significant relationships, role transitions, and interpersonal deficits (Craighead, Hart et al., 2002). IPT treatment “concentrates on the clients’ history of significant relationships, the quality and patterns of the clients’ interactions, the clients’ cognitions about themselves and their relationships, and the associated emotions” (Seligman & Reichenberg, 2007, p. 190). The most effective strategy at treating depression has been the combination of medication with professional counseling rather than either strategy alone (Craighead, Miklowitz et al., 2002).

**Pastoral Counselors/Biblical Counselors.** While “pastoral counseling” and “biblical counseling” are two distinct disciplines (Powlison & Coe, 1999), Conservative Holiness pastors use the terms “pastoral counseling” and “biblical counseling” interchangeably (C. Churchill, personal communication, April 10, 2013; S. Oliver, personal communication, April 10, 2013) perhaps due to a lack of exposure to the American Association of Pastoral Counselors (see Beck, 1999). As “biblical counseling” best encompasses the perspectives among literature, that will be the term used in this review of relevant literature.

Biblical counseling (also identified in the literature as “nouthetic counseling”) asserts that the Bible contains all the information necessary for counseling (Powlison & Coe, 1999). Those who counsel from this perspective posit that sin is the primary factor in the etiology of interpersonal problems and that emotional disorders do not exist (Adams, 1973). They view depression as a spiritual problem (Adams, 1970; LaHaye,

1974) that should be addressed preeminently in the context of church ministry and discipline and under the authority of the pastor (Adams, 1970).

Biblical counseling as a model for counseling was conceptualized primarily by Adams (Winfrey, 2007). It is confrontational in nature (Adams, 1970) with an emphasis upon giving information and direct advice (Peters & Carter, 1999). It is behaviorally focused. Biblical counseling has been embraced by other Fundamentalist traditions (see Vespie, 2010).

Others have conceptualized counseling approaches that use cognitive therapy integrated with scripture (see Crabb, 1977; Hart, 2001; Hart & Weber, 2002; Minirth & Meier, 1994; Tan & Ortberg, 2004). Those who endorse the Biblical counseling model, however, stand in direct opposition to this movement (Bobgan & Bobgan, 1985; Powlison, 1993); they posit that any models not built entirely upon the Bible are “fundamentally wrong” (Powlison, 1993, p. 1).

### **Role of Pastors in Treatment**

Gottlieb (1976) reviewed a number of large surveys (Eddy, Paap, & Glad, 1970; Gurin, Veroff, & Feld, 1960; Roberts, Prince, Gold, & Shiner, 1966; Rosenblatt & Mayer, 1972; Ryan, 1969) and concluded that those who seek help generally do not seek out mental health professionals; rather, they turn to other supports first (Hohmann & Larson, 1993; Wang et al., 2003). Ministers have been described as “front-line mental health workers” for Americans (Weaver, Flannelly, Garbarino, Figley, & Flannelly, 2003, p. 217).

Providing assistance to those in mental health distress was a central mission of the Christian church long before the advent of modern psychotherapy (Johnson & Jones, 2000). In fact, the concepts found in modern applications of counseling were articulated in early church fathers' writings on the subject of pastoral care (Clinton & Ohlschlager, 2002). Starting in the late nineteenth century, however, sacred and secular disciplines became at odds in their views on the identification and treatment of mental health issues. Early in the twentieth century, Freud (1959) posited a likeness between religious belief and neurotic obsession. He later argued that all religious ideas are rooted in wishes and illusions (see Nicholi, 2002). Similar sentiments were expressed by secular practitioners throughout the century. Skinner (1953) and Vetter (1958) both reduced religious belief to odd rituals that have been reinforced.

In 1957, the Joint Commission on Mental Illness and Health was established by the US Congress in order to assess the resources available to address mental illness. That commission developed a nationwide survey, the results of which were published in 1960. When asked of whom they sought help for emotional disturbances, 42% of individuals identified that they contacted a pastor. In contrast, 29% identified that they contacted their physicians and 27% identified that they contacted a mental health professional (Gurin et al., 1960).

When the study was replicated in 1976, those who identified seeking services from a mental health professional increased significant but those who contacted a pastor remained critical, at 39% (Veroff, Kulka, & Douvan, 1981). Pastors continued to have an important role even with the increase in popularity of mental health professionals

(McMinn et al., 2006). Four reasons posited to explain why pastors are consulted in times of psychological distress include: seeking different goals than those found in psychological help; seeking a familiar environment; seeking to be seen in an environment with less stigma; seeking spiritual counseling (Chaifant et al., 1990).

### **Pastors as Counselors**

A review of ten research studies identified that pastors spend 7.5 hours each week providing counseling (Weaver, 1995). They report that most of their counseling is with marriage and family issues, grief and loss, spiritual concerns, depression, anxiety and guilt, and premarital concerns (Abramczyk, 1981; Lowe, 1986; Ruppert & Rogers, 1985; Virkler, 1979). Pastors reported that most issues are addressed in about four sessions (Abramczyk, 1981). Most often the content of counseling done by pastors focuses on biblical perspectives on the presenting issue and the use of spiritual resources (Beck, 1999). Those pastors who do have more education and psychology courses note that they use more typical psychological counseling strategies (Lowe, 1986; Ruppert & Rogers, 1985) and are more willing to refer to mental health professionals (Meylink & Gorsuch, 1988). In previous studies, pastors have reported a desire to receive additional training in counseling and psychology (Abramczyk, 1981; Lowe, 1986; Ruppert & Rogers, 1985; Virkler, 1979).

## **Referral Patterns of Pastors**

Pastors have a variety of professionals to whom they can refer for professional mental health services: psychiatrists, psychologists, and marriage and family therapists (Cook, 1999). Historically, referral rates from pastors to mental health professions have been low (Abramczyk, 1981; Bell, Morris, Holzer, & Warheit, 1976; Lowe, 1986; Virkler, 1979). Previous research has demonstrated that referral patterns are related to the visibility of professionals in different areas (Meylink & Gorsuch, 1988). Other studies have shown that the perceived religious views of mental health professions influence whether or not pastors will consider them to be a resource (Gass, 1984; Haugen & Edwards, 1976; Hong & Wiehe, 1974).

A number of factors have been offered as means to explain the low rates of referral from pastors to mental health professionals. For one, both parishioners and their pastors are not comfortable with the idea of mental health treatment with a provider who may have beliefs that are inconsistent with their own (Clark & Thomas, 1979; Dougherty & Worthington, 1982; Gass, 1984; King, 1978), particularly the fear that their religious concerns may be interpreted as pathology (Mollica, Streets, Boscarino, & Redlick, 1986). Another factor relates to the fact that those who seek services from pastors often do so without charge; parishioners may not seek referral to mental health professionals due to their perception of the expense involved (Abramczyk, 1981; Sell & Goldsmith, 1988).

A final factor that has been considered is the overall lack of cooperation between pastors and mental health professions, not just pastors' perception of mental health professionals. Pastors actually refer to mental health professionals with far more

frequency than they receive referrals in return (Bell et al., 1976; Gorsuch & Meylink, 1988; Mollica et al., 1986). McDonald (1984) posited that this may imply a “gatekeeper model” in which mental health professionals view the only function of pastors related to mental health issues is to refer. This one-directional relationship may also lead to low referral rates (Azlin, 1993; McMinn et al., 2005).

Larson (1967) noted a number of variables significantly influenced the opinions of pastors related to mental illness; these variables included age, denominational affiliation, size of the congregation, father’s occupation and education, education, college major, pastoral counseling training, and the number of emotionally distressed persons seen.

Pastors that self-identified themselves as theologically conservative are more likely to conceptualize mental health issues in terms of morality and religion (Clark & Thomas, 1979; Mollica et al., 1986). Theologically conservative pastors have demonstrated a tendency to characterize mental health systems as sexually-focused, agnostic, humanistic, and/or amoral (Clark, & Thomas, 1979; King, 1978; Virkler, 1979). Pastors who self-identified as conservative in theology were significantly less likely to make referrals (Mannon & Crawford, 1996). When they did, they believed it much more important that the mental health professional share their values and beliefs (Mannon & Crawford, 1996).

Pastors identified as Fundamentalists have been the most concerned about the religious orientation of mental health professionals (Mollica et al., 1986; Wright, 1984), the furthest from the psychiatric norm related to opinions of mental distress (Larson,

1967), and the least likely to even respond to questionnaires on the topic (Larson, 1968). Early studies used a broad definition for Fundamentalist pastors (Larson, 1967, 1968). Lamberton (1992) specifically targeted Fundamentalist pastors and provided a clearer definition of Fundamentalism as used in the study of practical theology (Dillenberger & Welch, 1954): a belief in the inerrancy of scripture that includes a literal acceptance of the Genesis creation story, the virgin birth, heaven and hell, and other similar doctrines. They place a lower value on counseling when compared to their more liberal colleagues (Cumming & Harrington, 1963). They view counseling as a role of the pastor (Benner, 1988; Gilbert, 1981; Larson, 1964). When they do refer, they view the religious background of the mental health professional as far more important than others (Wright, 1984).

Studies that have focused on other descriptive variables have found that willingness to refer is effected by the age of the pastor (Fulz, 2002), the pastor's level of education and mental health training (Fulz, 2002; Guinee & Tracey, 1997), the pastor's denomination (Myers, 2000), and the size of congregation (Gorsuch & Meylink, 1988; Mannon & Crawford, 1996). A synthesis of those studies posits that pastors over the age of 40 are more likely to refer to mental health counseling; pastors with more education and training were more likely to refer to mental health counseling; and pastors with larger congregation were more likely to refer to mental health professionals.

## **Chapter Summary**

Pastors play such an instrumental role in counseling and referring their parishioners to counseling that research into their views and practices are necessary. Pastors who self-identify as part of the Conservative Holiness Movement are unique in that they embrace a Wesleyan-Arminian theology but with an element that leans toward Fundamentalism. Studying this group of pastors will provide insight into both groups and their attitudes about professional mental health counseling for depression as well as their willingness to refer for treatment.

Chapter Three will describe the methodology used to investigate this group of pastors. Chapter Four will describe the study participants and provide the research results. Chapter Five will interpret those findings, discuss the implications for both pastors and mental health professionals, and relay both recommendations for future research and study limitations.

## CHAPTER THREE: METHODS

The purpose of this investigation is two-fold. First, this study investigated whether Conservative Holiness are willing and able to assess for depression. Second, this study investigated if there are any significant interaction effects among the predictor variables relative to their willingness to refer depressed parishioners to mental health professionals. This chapter includes discussion related to research design, sample population, instrumentation and its administration, as well as data processing and analysis. It closes with reflections on ethical considerations.

### **Research Design**

This study required a descriptive study that investigated the views of Conservative Holiness pastors. A longitudinal study that followed participants over time would not fit this study as the population was investigated at a specific point in time. A cross-sectional survey was chosen as this design has been shown to be an effective strategy when working with attitudes, values, and beliefs (Creswell, 2003) and can be conducted in a short period of time and with little cost (Simon, 2002).

One factor in assessing differences in variables relates to response rates of study participants. Larson (1964) noted that pastors from more liberal, mainline denominations had a response rate of 63% while Fundamentalist pastors had a response rate of 27%. Similar concerns were noted by Meylink and Gorsuch (1988) and Mollica and colleagues

(1986). In order to compensate for the low return rate, Lamberton (1992) used telephone communications to coordinate face-to-face interviews; this strategy yielded a 75% response rate. Rather than employing that strategy, data was collected at a gathering where participants would congregate in large numbers.

Another factor is the variations among pastors related to their familiarity with diagnostic terminology (Meylink & Gorsuch, 1988). In order to minimize this factor, many of the studies related to pastors' views on mental health issues have made use of vignettes. Larson (1968) created a series of case studies; pastors were instructed to review the information presented in the case studies and to rate both the degree of emotional distress and the extent to which pastors should be involved in treatment. This collection of vignettes has been used in a variety of subsequent studies (see Azlin, 1993; Lamberton, 1992).

### **Participants**

The participants surveyed consisted of Conservative Holiness pastors that are actively pastoring Conservative Holiness churches. The Conservative Holiness Movement does not consist of one specific denomination but a collection of denominations and independent churches united because of their identification as evangelical Christians with a historical Wesleyan-Methodist message and a desire to maintain behavioral standards (Black, 2003; England, 1998). Black (2003) noted 17 groups that are made up of more than 12 local churches each. These groups vary in historical development, geographical location, and denominational structure; yet, they are

united in their participation in and support of the Interchurch Holiness Convention. For this reason, the April 2012 Interchurch Holiness Convention (IHC) was selected as the best venue to collect data for this investigation.

Each registered attendee at the April 2012 Interchurch Holiness Convention received a welcome packet that included, among many other fliers and advertisements, an invitation for “Conservative Holiness pastors who are actively pastoring Conservative Holiness churches” to participate in a study seeking to investigate “views on depression and your response as pastor” (see Appendix A). In addition, announcements were included in daily printed programs to remind pastors of the invitation to participate (see Appendix B).

All pastors in attendance who self-identified as Conservative Holiness who were actively pastoring churches that identify as Conservative Holiness were invited to participate. Since gender, age, race, and marital status were all variables under investigation, there were no restrictions related to them. Other key variables included the pastor’s education level, counseling training, years of pastoral ministry, and size of the church; as a result, there were no minimum or maximum requirements on these variables for inclusion. Denomination of pastor and church were both write-in blanks as listing out the possibilities would have taken too much space; pastors were reminded when taking the survey that they needed to self-identify as Conservative Holiness and their church needed to do so as well.

A number of licensed/ordained pastors from Conservative Holiness groups serve in capacities other than pastor; mainly in the role of evangelist, educator, or missionary.

These licensed/ordained pastors were excluded from the study unless they also had pastoral responsibilities.

Pastors volunteered to participate in the study by stopping by the display booth in the exhibitor's area and taking a survey packet during the convention. This venue was chosen because it is the largest gathering made up of almost exclusively those self-identifying as Conservative Holiness (Kostlevy, 2009) and because the convention leadership had given permission for the event to be used as a point of data collection. The data collection was through a self-administered survey (Fink, 1995) completed and returned during the three-day convention. A total of 120 survey packets were distributed upon request; 86 were returned completed.

### **Instrumentation**

Participants were asked to complete a 4-page instrument (Appendix C) that included four parts. Part 1 collected participant demographic information. Part 2 sought to establish the participants' ability to assess for the severity of depression, their perception of their own competency to provide assistance to varying degrees of depression, their views on potential providers to whom they would consider referring parishioners, and their views on moral implications of depressive symptoms. Part 3 measured their attitudes toward mental health and mental health professionals and their perceived competency. Part 4 inquired as to the participant recognition of their own need for help and confidence in mental health professionals.

## **Part 1 Demographics Questionnaire**

The information collected in the first section related to the pastor's demographic information to include gender (male; female), age (under age 25; 26-40; 41-55; 56-70; over age 71), race (white; other), marital status (never married; married; separated; divorced; widowed), education (high school; some college; bachelor's degree; some graduate work; graduate degree), college (Alleghany Wesleyan College; God's Bible School and College; Hobe Sound Bible College; Penn View Bible Institute; Union Bible College; and other), counseling training (none; 1 course; 2-3 courses; 4-5 courses; 6 or more courses), years of pastoral ministry (under 5 years; 6-20 years; 21-35 years; 36-50 years; more than 50 years), denomination, and size of church (attendance under 20; 21-40; 41-60; 61-80; more than 81). For each item, participants were instructed to "check the appropriate box" with the exception of the participant's denomination and the denomination of the church; those two items were fill-in-the-blank.

## **Part 2 Case Studies**

The second section included five case studies. This strategy was developed by Larson (1968) and employed by Lamberton (1992) and Azlin (1993) in their respective studies related to pastors' views on mental illness. For the purposes of this study, the case studies were revised in order to investigate research questions specifically related to depression.

The case studies included in this section were as follows:

Case 1. Mrs. Brown is in her late forties; she is married with three children. She tends to avoid social gatherings, even at church. She has struggled with her weight and feels self-conscious about this. She has frequent doubts about her faith in God. She says that she has struggled with feeling hopeless for years.

Case 2. Mr. Johnson is a college student in his early twenties. He is single and has dated infrequently. His degree is in General Studies and he doesn't know what he wants to do after graduation. He enjoys a variety of activities but doesn't feel a call to any specific vocation. He is frustrated at being pressured to find a steady girlfriend. He says that he prays to God but doesn't seem to be getting any direction.

Case 3. Mrs. Smith is in her early sixties. She has lost 25 pounds in the last 2 months though she hasn't been trying to. She doesn't feel like eating and finds herself sleeping most of the day. Since her husband's death last year, she says that she no longer has anything to wake up for. She feels sad all the time. Her doctor has found nothing wrong with her physically.

Case 4. Mr. Williams is in his early-thirties. He is married with a young son but he and his wife have recently separated and she and their son have moved out. Since they left, he has lost all interest in his normal activities; he recently began giving away some of his possessions. He says that "life isn't worth living" anymore since he feels as though his family and God have turned their back on him. He says that he has a gun and that after saying goodbye to his son, he plans to shoot himself in the head.

Case 5. Mr. Jones is in his mid-fifties. He is married with two teenage children. He was laid-off from his full-time job three months ago and has been unable to find steady work. He is having difficulty sleeping at night and is fatigued throughout the day. He says that he feels worthless because he has been unable to provide for his family.

In response to each case study, participants were instructed to assess the extent of depression therein (no evidence of depression; evidence of mild depression; evidence of moderate depression; evidence of severe depression), to assess the extent to which they would be able to help (could handle the case alone; could provide major assistance in conjunction with a professional; could provide some assistance in conjunction with a professional; not adequately trained and would refer to a professional), to assess as to any

appropriate person to whom the case study should be referred (no one; another pastor; family physician; pastoral counselor; mental health professional), and to assess whether they believe that the depressive symptoms were indicative of immoral behavior (yes; not sure/undecided; no). Participants were also instructed to indicate if they believed that the depression was immoral behavior in each case though this information was not used as part of this study due to feedback from participants that they found this item unclear. Each item was a check-box.

### **Part 3 Opinion Statements Instrument**

The third section consisted of 33 opinion statements that comprise three scales: Attitudes toward Mental Health Scale, Causes of Depression Scale, and the Perceived Competency Scale. These were created initially by Larson (1964, 1968) and revised by Azlin (1993); they were “designed to measure the pastors’ attitudes toward mental health services and practitioners, their beliefs about the cause of mental illness, and their perceived competence to treat emotional disturbances” (Lamberton, 1992, p. 13). As this study focused more narrowly, specifically on depression, some items were reworded to reflect this concentration. While the items from the Causes of Depression scale were included in the instrument, the data was not analyzed as it was not relevant to this study. Responses were to be identified on a 5-point Likert scale (strongly agree, partly agree, not sure, partly disagree, strongly disagree).

Attitudes toward Mental Health Scale:

5. When you get right down to it, depressed parishioners should not be a clergyman's responsibility. Therefore, they should be referred to mental health practitioners.
8. Mental health practitioners are too evasive when it comes to facing a problem.
14. I feel the work of a mental health practitioner conflicts with the work of a pastor.
20. I feel the majority of emotional disturbances should be handled by the clergyman.
22. On the whole, mental health practitioners are very competent.
23. Psychiatric treatment takes too much time and gets too poor results.
25. The mental health practitioner's attitude toward the patient and his problem is for the most part a positive one.
26. In my opinion there are more "odd-balls" in psychiatry than any other profession.
29. I feel that mental health practitioners overemphasize the sexual aspects of life as a cause of mental disorders.
32. I have been greatly impressed by the results of psychiatric treatment.

Causes of Depression Scale:

2. Loneliness is a cause of depression.
3. Trouble getting along with one's wife or husband is a cause of depression.
6. Demonic influence is a cause of depression.
9. Drinking too much is a cause of depression.
11. Lack of religious belief is a cause of depression.
12. Not enough will power, lack of self-control, is a cause of depression.
15. Trouble getting along on the job is a cause of depression.
17. Stress is a cause of depression.
18. Excessive drug use causes depression.
21. Masturbation is a cause of depression.
24. Depression is learned.
27. Depression is inherited.
30. A run-down physical condition is a cause of depression.
33. Sex habits are a cause of depression.

Perceived Competency Scale:

1. In general, I feel quite comfortable in caring for depressed parishioners.
4. I feel pretty competent and comfortable in talking with parishioners about their personal problems.

7. My training and experience are such that I feel competent to take on most cases of depression among my parishioners.
10. I do not know what to do for many of my depressed parishioners.
13. I do not have the background to help depressed parishioners.
16. My training and experience in handling depressed parishioners are adequate.
19. My background severely limits my having much success with depressed parishioners.
28. I have a good understanding of how to help depressed parishioners.
31. Most depressed parishioners need more help than I can give.

#### **Part 4 Attitudes Toward Seeking Professional Psychological Help: Short Form**

The fourth section consisted with 10 statements from the Attitudes Toward Seeking Professional Psychological Help: A Shortened Form (Fischer & Farina, 1995), again revised such that they were more specifically consistent with the research questions relating to depression. Statements each corresponded to either the Recognition of the Need for Help Scale or the Confidence in Mental Health Professionals Scale. Each was hypothetical in nature, assessing the participants' willingness to seek professional help should they be demonstrating symptoms of depression. Responses were again identified by circling agreement/disagreement – this time on a 4-point Likert scale (agree, partly agrees, partly disagree, disagree).

##### Recognition of the Need for Help:

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

10. Personal and emotional trouble, like many things, tend to work out by themselves.

#### Confidence in Mental Health Professionals:

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

### **Assumptions and Limitations**

This investigation involved the use of vignettes. Depression is too complex to properly encapsulate in five vignettes. It was assumed that pastoral views would change depending on the vignettes provided and that other vignettes could provide different responses.

This investigation involved a self-report survey. It assumed that pastors were honest in their responses; study materials were clear that responses would remain anonymous and confidential in an effort to limit the risk of dishonest responses. Yet, the desire to demonstrate competency in this area may have contributed to bias.

The instrument combined several disciplines (psychologist, psychiatrist, clinical social worker, psychiatric nurse, marriage and family therapist, and licensed professional counselor) into one category: mental health professional; yet, pastoral counselor was presented individually. While pastoral counselors do have differing theoretical and

practical strategies (Benner, 2003), the extent to which participants understand these nuances is unknown.

While surveys were administered at the Interchurch Holiness Convention, the largest gathering of Conservative Holiness pastors, it is possible that the 86 participants were not representative of the up to 3,000 Conservative Holiness pastors.

Conservative Holiness pastors are unique in that they are Wesleyan-Arminian in theological orientation (Thornton, 1998) yet have separatist tendencies most often associated with Fundamentalism (Sidwell, 1998). It should not be assumed that results can be generalized to either Wesleyan-Arminian pastors in general nor Fundamentalist pastors in general.

The investigator is not a Conservative Holiness pastor nor a member of a Conservative Holiness church yet does identify as Conservative Holiness, is a graduate of a Conservative Holiness Bible college, is on the board of directors for that Conservative Holiness Bible college, and has consulted with Conservative Holiness pastors and churches on issues related to mental health and counseling.

### **Research Procedures**

The Liberty University Institutional Review Board (IRB) approved this study on April 3, 2012. Study participants were recruited at the Interchurch Holiness Convention (IHC) held in April of 2012 in Dayton, Ohio. The IHC is recognized as the largest gathering of those who identify as being part of the Conservative Holiness Movement (CHM). Invitations for CHM-identifying pastors to participate in the study were

included in the conference registration packets (Appendix A) and in the daily program (Appendix B) that included the schedule of events and conference-associated advertising. Interested pastors were invited to stop by the investigator's booth in the exhibitor's area in order to express an interest in participating. The choice of one of two books was offered as an incentive. Candy was offered to any passersby whether they chose to participate or not.

The investigator's booth in the exhibit hall included promotional materials related to the study (see Appendix A, Appendix B), a framed copy of the Consent form (see Appendix C), the survey packets (Appendix D), pens to be used to complete the packet, copies of the books to be given as incentives for participation, and a sealed box for participants to return their sealed packets. For the entirety of the three-day conference, the exhibit booth was manned by the investigator or an associate who had been debriefed on how to address any basic questions or concerns. The survey packet included a copy of the Consent, the 4-page survey, and a note of thanks (Appendix E).

The Consent form (see Appendix C) provided information as to the title of the study, the primary investigator with associated credentialing and affiliation, and a brief overview of the study. A note of background information was provided as well as information related to the procedures associated with participation. Risks and benefits of being in the study were listed and compensation for participation was explained. Confidentiality was addressed; information related to the usage and storage of records was outlined so as to be clear that privacy was assured. The voluntary nature of

participating was also noted. Contact information for the investigator, advisor, and Institutional Review Board chairperson were provided.

The final form in the survey packet (see Appendix E) included a note of thanks as well as reminders related to the procedure for returning the completed packet and information to be used in the selection of the book received in compensation for participating.

During the three-day conference, 120 survey packets were distributed to those requesting to participate. At the close of the conference, 86 completed surveys were found to have been returned to the sealed collection box. This number corresponded to the number of books that were distributed.

### **Research Questions and Hypotheses**

The research questions posed in this investigation were:

1. Are Conservative Holiness pastors willing and able to assess depression in their parishioners?

*Null Hypothesis One:* Conservative Holiness pastors are unwilling or unable to assess for depression.

*Alternative Hypothesis One:* Conservative Holiness pastors are willing and able to assess for depression.

2. What are the factors that are associated with Conservative Holiness pastors' willingness to consider referral to mental health professionals?

*Null Hypothesis Two:* Education, counseling training, years of pastoral ministry, and size of church will have no significant influence upon Conservative Holiness pastors' ability to accurately assess for depression and willingness to refer to mental health professionals.

*Alternative Hypothesis Two:* Education, counseling training, years of pastoral ministry, and size of church will influence Conservative Holiness pastors' ability to accurately assess for depression and willingness to refer to mental health professionals. Specifically it is hypothesized that these variables related to exposure to mental health issues will be positively correlated with ability to accurately assess for depression and willingness to refer to mental health professionals.

*Null Hypothesis Three:* Attitudes toward mental health professionals and their services as well their Perceived Competency to assist those with depression will have no significant influence upon Conservative Holiness pastors' willingness to refer to mental health professionals.

*Alternative Hypothesis Three:* Attitudes toward mental health professionals and their services as well their Perceived Competency to assist those with depression will influence Conservative Holiness pastors' willingness to refer to mental health professionals. Specifically it is hypothesized that positive attitudes of mental health

professionals and their services and high levels of perceived competency will be positively correlated with a willingness to refer to mental health professionals.

*Null Hypothesis Four:* Conservative Holiness pastors' Recognition of Need for Help and their Confidence in Mental Health Professionals will have no significant influence upon their willingness to refer to mental health professionals.

*Alternative Hypothesis Four:* Conservative Holiness pastors' Recognition of Need for Help and their Confidence in Mental Health Professionals will influence their willingness to refer to mental health professionals. Specifically it is hypothesized that high recognition of need and high confidence in mental health professionals will be positively correlated with a willingness to refer to mental health professionals.

### **Data Processing and Analysis**

The purpose of this investigation was to assess Conservative Holiness pastors' willingness and ability to assess depression and various factors impacting their willingness to refer to a mental health professional. Data analysis was completed using IBM SPSS software.

The plan to address the first research question was to review frequency tables to determine whether or not Conservative Holiness pastors were able to accurately assess for depression in the provided scenarios. Chapter Four provides these findings.

The plan to address the second research question was to complete logistic regression analysis to see which variables were predictive of willingness to refer to

mental health professionals. Chapter Four explains why other strategies were employed and provides the relevant findings.

### **Ethical Considerations**

This investigation protected the right of each participant. Each participant was provided an opportunity to review the informed consent as a copy was on display at the locations in which survey packets were picked up and dropped off as well as inside the survey packet itself. Prospective participants were informed of the purpose of the investigation as well as any applicable risk and potential benefits. Confidentiality was guarded in that the survey was anonymous and participation was entirely voluntary. Surveys remained free from identifying information during collection, storage, analysis and reporting. Consistent with the ethical mandates found in the Data Protection Act of 1998:

The data will be used exclusively for research purposes. The information will not be used to support measures or decisions relating to *any* identifiable living individual. The data will not be used in a way that will cause, or is likely to cause, substantial damage or substantial distress to any data subject. The results of this research, or any resulting statistics, will not be available in a format that will identify the data subject. Proper consents have been obtained. Security procedures (collecting and storage) for protecting data relevant to internet surveys utilized for this study have been identified and implemented by researcher. Data stored on researcher's computer will be password protected. Data will be stored and securely locked in a file cabinet in the researcher's home. (Data Protection Act, 1998, pp. 1-3)

## Chapter Summary

The purpose of this investigation was to assess Conservative Holiness pastors' willingness and ability to assess depression and their willingness to refer to mental health professionals. Participants were Conservative Holiness pastors who responded to conference advertising, picked up survey packets, and anonymously completed a four-part survey during the April 2012 Interchurch Holiness Convention. The two research questions were to be tested using frequency analysis and logistic regression. The data and results were protected in accordance with research ethical standards and IRB requirements.

## CHAPTER FOUR: RESULTS

The purpose of this investigation is two-fold. First, this study investigated whether Conservative Holiness are willing and able to assess depression in their parishioners. Second, this study investigated if there are any significant interaction effects among the predictor variables relative to their willingness to refer depressed parishioners to mental health professionals. This chapter presents the results of this investigation. Research questions and hypotheses are addressed along with results of the respective analysis. Finally, the results are summarized.

### **Sample Data**

The demographic variables investigated included age, gender, race, marital status, education, college, counseling training, years of pastoral ministry, pastor's denomination, church's denomination, and size of church. Eighty-six questionnaires were returned and used in this analysis.

As depicted in Table 4.1, participants were quite homogenous in gender (93% male), race (97% white), and marital status (94% married). The most represented age group included those ages 41-55 (40%) followed those ages 56-70 (26%) and those ages 26-40 (24%). The majority of participants had a bachelor-level education (52%). Most reported that they had either no counseling training (36%) or only one counseling course as part of their training (27%). The most represented length of full-time pastoral ministry

was 6-20 years (44%) followed by 21-35 years (26%). Most of the participants pastored churches with attendance ranging between “more than 81” (35%) and 41-60 (23%).

Table 4.1

*Characteristics of Participants as Frequencies and Percentages*

Characteristics	<i>n</i>	%
<b>Gender</b>		
Male	80	93.0
Female	1	1.2
<b>Age of Pastor</b>		
Under age 25	4	4.7
Age 26-40	21	24.4
Age 41-55	34	39.5
Age 56-70	22	25.6
Over age 71	5	5.8
<b>Race of Pastor</b>		
White	83	96.5
Other	2	2.3
<b>Marital Status</b>		
Never Married	1	1.2
Married	81	94.2
Divorced	1	1.2
Widowed	2	2.3
<b>Education</b>		
High School	4	4.7
Some college	18	20.9
Bachelor’s degree	45	52.3
Some graduate work	6	7.0
Graduate degree	12	14.0

Characteristics	<i>n</i>	%
<b>College</b>		
Alleghany Wesleyan College	3	3.5
God's Bible School and College	25	29.1
Hobe Sound Bible College	9	10.5
Penn View Bible Institute	11	12.8
Union Bible College	10	11.6
Other	24	27.9
<b>Counseling Training</b>		
None	31	36.0
1 course	23	26.7
2-3 courses	15	17.4
4-5 courses	5	5.8
6 or more courses	6	7.0
<b>Years of Pastoral Ministry</b>		
Under 5 years	8	9.3
6-20 years	38	44.2
21-35 years	22	25.6
36-50 years	15	17.4
51 or more years	1	1.2
<b>Church Attendance</b>		
Under 20 parishioners	10	11.6
21-40 parishioners	17	19.8
41-60 parishioners	20	23.3
61-80 parishioners	8	9.3
81 or more parishioners	30	34.9

Participants were invited to write-in their denomination with which they are credentialed and the denomination of the church they pastor. A total of 22 different answers were provided. The most represented denominations of the pastor were the Bible Methodist Connection of Churches (31%) and God's Missionary Church (14%). The most

represented denominations of the church were also the Bible Methodist Connection of Churches (21%) and God's Missionary Church (12%) while the largest response indicated was that the church itself was independent (27%).

### **Data Analysis and Results**

Frequency data was used in order to investigate participants' willingness and ability to assess for depression. Due to small sample size, logistic regression analysis was not an appropriate statistical strategy to investigate if variables were predictive of the willingness for a pastor to refer to mental health professionals. Instead, parametric and non-parametric statistical procedures were used. Relationships with demographic variables were analyzed using Spearman's rho and independent t-tests. Relationships with variables from the scales were analyzed using Pearson Product-Moment Correlation.

Research Question 1:

Are Conservative Holiness pastors willing and able to assess depression in their parishioners?

Hypothesis 1:

*Null Hypothesis One:* Conservative Holiness pastors are unwilling or unable to assess for depression.

*Alternative Hypothesis One:* Conservative Holiness pastors are willing and able to assess for depression.

Participants were prompted to read five case studies and answer questions based upon those scenarios. This strategy was employed by Larson (1964, 1968) and used by Lamberton (1992) and Azlin (1993). The scenarios were revised for this investigation in order to concentrate specifically on depression.

The first question asked the extent to which the individual in the scenario is depressed (no depression, mild depression, moderate depression, severe depression). The second question asked the extent to which the pastor could help the individual (handle alone, provide major assistance in conjunction with a professional, provide some assistance in conjunction with a professional, not adequate trained other than to refer). The third question asked if the pastor would refer the individual and to whom would they refer them (another pastor, physician, pastoral counselor, mental health professional).

The first scenario described Mrs. Brown, a female in her late forties who is married with three children. The case study was written with symptomology consistent with mild depression. Symptoms were noted to include avoiding social gatherings, struggling with her weight, feelings of self-consciousness, religious doubt, and feelings of hopelessness. Findings are displayed in Table 4.2.

Participants most frequently assessed that Mrs. Brown demonstrates evidence of moderate depression (51%). They most frequently stated that they would be able to provide her some assistance in conjunction with a professional (66%). Those who indicated that they would consider referral most frequently indicated that they would refer Mrs. Brown to a pastoral counselor (49%).

Table 4.2

*Assessment of Mrs. Brown as Frequencies and Percentages*

	<i>n</i>	%
<b>Severity of Depression</b>		
No evidence of depression	0	0.0
Mild depression	27	31.4
Moderate depression	44	51.2
Severe depression	15	17.4
<b>Extent to which they could help</b>		
Could handle alone	8	9.3
Major assistance in conjunction with professional	14	16.3
Some assistance in conjunction with professional	57	66.3
Not adequately trained except to refer	6	7.0
<b>To whom they would refer</b>		
Another pastor	9	10.4
Family physician	17	19.8
Pastoral counselor	42	48.8
Mental health professional	16	18.6

The second scenario described Mr. Johnson, a male in his early twenties who is single. The case study was written without any expressed symptomology consistent with depression. Presenting issues were noted to include insecurity about plans following college and his inability to find a steady girlfriend.

Participants were more likely (51%) to assess that Mr. Johnson demonstrates no evidence of depression. Respondents frequently stated that they could handle this situation without the assistance of a professional (58%) and that they would not refer Mr. Johnson at all (49%).

Table 4.3

*Assessment of Mr. Johnson as Frequencies and Percentages*

	<i>n</i>	%
<b>Severity of Depression</b>		
No evidence of depression	44	51.2
Mild depression	37	43.0
Moderate depression	4	4.7
Severe depression	1	1.2
<b>Extent to which they could help</b>		
Could handle alone	50	58.1
Major assistance in conjunction with professional	18	20.9
Some assistance in conjunction with professional	13	15.1
Not adequately trained except to refer	4	4.7
<b>To whom they would refer</b>		
Another pastor	14	16.3
Family physician	0	0.0
Pastoral counselor	35	40.7
Mental health professional	0	0.0

The third scenario described Mrs. Smith, a female in her late sixties who is recently widowed. The case study was written with symptomology consistent with moderate depression. Symptoms were noted to include losing weight without trying, sleeping much of the day, feeling sad all the time. See Table 4.4 for findings.

Participants most frequently assessed that Mrs. Smith demonstrates evidence of severe depression (70%). They most frequently stated that they would be able to provide her some assistance in conjunction with a professional (48%). They most frequently indicated that they would refer Mrs. Smith to a mental health professional (52%).

Table 4.4

*Assessment of Mrs. Smith as Frequencies and Percentages*

	<i>n</i>	%
<b>Severity of Depression</b>		
No evidence of depression	1	1.2
Mild depression	1	1.2
Moderate depression	22	25.6
Severe depression	60	69.8
<b>Extent to which they could help</b>		
Could handle alone	5	5.8
Major assistance in conjunction with professional	14	16.3
Some assistance in conjunction with professional	41	47.7
Not adequately trained except to refer	25	29.1
<b>To whom they would refer</b>		
Another pastor	4	4.7
Family physician	19	22.1
Pastoral counselor	37	43.0
Mental health professional	45	52.3

The fourth scenario described Mr. Williams, a male in his early thirties who is recently separated with one child. The case study was written with symptomology consistent with severe depression. Symptoms were noted to include losing interest in normal activities, giving away possessions, feeling as though life is not worth living, and feeling as though God and family have turned their back on him. In addition, the scenario indicated that Mr. Williams has immediate plans and intent to shoot himself in the head. See Table 4.5 for a depiction of this question.

Table 4.5

*Assessment of Mr. Williams as Frequencies and Percentages*

	<i>n</i>	%
<b>Severity of Depression</b>		
No evidence of depression	0	0.0
Mild depression	2	2.3
Moderate depression	1	1.2
Severe depression	82	95.3
<b>Extent to which they could help</b>		
Could handle alone	1	1.2
Major assistance in conjunction with professional	7	8.1
Some assistance in conjunction with professional	42	48.8
Not adequately trained except to refer	32	37.2
<b>To whom they would refer</b>		
Another pastor	2	2.3
Family physician	10	11.6
Pastoral counselor	32	37.2
Mental health professional	70	81.4

Participants most frequently assessed that Mr. Williams demonstrates evidence of severe depression (95%). They most frequently stated that they would be able to provide him some assistance in conjunction with a professional (49%). They most frequently indicated that they would refer Mr. Williams to a mental health professional (81%).

The fifth scenario described Mr. Jones, a male in his mid-fifties who is married with two children. The case study was written with symptomology consistent with moderate depression. Symptoms were noted to include having trouble finding work after

being laid off, having difficulty with sleeping, having fatigue through the day, and feelings of worthlessness. See Table 4.6.

Table 4.6

*Assessment of Mr. Jones as Frequencies and Percentages*

	<i>n</i>	%
<b>Severity of Depression</b>		
No evidence of depression	1	1.2
Mild depression	29	33.7
Moderate depression	48	55.8
Severe depression	6	7.0
<b>Extent to which they could help</b>		
Could handle alone	10	11.6
Major assistance in conjunction with professional	21	24.4
Some assistance in conjunction with professional	48	55.8
Not adequately trained except to refer	5	5.8
<b>To whom they would refer</b>		
Another pastor	7	8.1
Family physician	7	8.1
Pastoral counselor	55	63.9
Mental health professional	15	17.4

Participants most frequently assessed that Mr. Jones demonstrates evidence of moderate depression (56%). They most frequently stated that they would be able to provide him some assistance in conjunction with a professional (56%). They most frequently indicated that they would refer Mrs. Brown to a pastoral counselor (64%).

To test for accuracy, participants' scores related to the extent of depression in each scenario were compared with the answers given by a licensed mental health professional. Table 4.7 provides the clinical assessment for each scenario as well as the weighting of scores used to calculate diagnostic accuracy.

Table 4.7

*Assessment and Scoring used to calculate Diagnostic Accuracy*

Case Study	Assessment	Weighting of Scoring		
		Mild	Moderate	Severe
Mrs. Brown	Mild Depression	1.0	0.5	0.0
Mr. Johnson*	No Evidence	0.0	0.0	0.0
Mrs. Smith	Moderate Depression	0.0	1.0	0.5
Mr. Williams	Severe Depression	0.0	0.0	1.0
Mr. Jones	Moderate Depression	0.0	1.0	0.0

Using the weighting system provided in Table 4.7, participants were assigned a Diagnostic Accuracy score between 0.0 (no assessments were correct out of five) and 5.0 (all five assessments were correct). No participants earned a 0.0 and no participants earned a 5.0. The mean score was 2.92 with a standard deviation of .78. The most represented responses were 3.0 (25.0%) and 2.5 (23.8%). Table 4.8 provides detailed frequency and percentage data related to Diagnostic Accuracy, further confirming the acceptance of the null hypothesis.

The null hypothesis is rejected based upon the results of the statistical analysis. As noted in Tables 4.2 through 4.6, the participants were willing to assess for depression. As noted in Table 4.8, they did so with fairly good accuracy.

Table 4.8  
*Assessment Scores as Frequencies and Percentages*

Correct Assessment Score	<i>n</i>	%
0.5	0	0.0
1.0	2	2.4
1.5	4	4.7
2.0	9	10.7
2.5	20	23.8
3.0	21	25.0
3.5	12	14.3
4.0	15	17.9
4.5	1	1.2
5.0	0	0.0

Research Question 2:

What are the factors that are associated with Conservative Holiness pastors' willingness to consider referral to mental health professionals?

In this sample, seventy-two of eighty-six Conservative Holiness pastors identified at least one scenario in which referral to a mental health professional would be considered (83.7%).

Table 4.9 provides detailed information as to the number of participants and percentage who would refer each case study to a mental health professional.

Table 4.9

*Referral to a Mental Health Professional as Frequencies and Percentages*

Case Study	Severity of Depression	<i>n</i>	%
Mrs. Brown	Mild	16	18.6
Mr. Johnson	No Evidence of Depression	0	0.0
Mrs. Smith	Moderate	45	53.6
Mr. Williams	Severe	70	81.4
Mr. Jones	Moderate	15	17.4

Table 4.10

*Number of times Referral to a Mental Health Professional as Frequencies and Percentages*

Number of Case Studies	<i>n</i>	%
0 cases referred to a mental health professional	13	15.1
1 case referred to a mental health professional	22	25.6
2 cases referred to a mental health professional	28	32.6
3 cases referred to a mental health professional	14	16.3
4 cases referred to a mental health professional	5	5.8

*Note:* Only 4 out of the 5 case studies included symptoms of depression.

While no participant felt that every case study should be referred to a mental health professional, a total of 5 students (5.8%) suggested that every depressed case should be thus referred. More than half of the participants indicated that at least 2 of the cases should be referred (54.7%). Thirteen of the participants never selected mental health professional as a recommended referral (15%). Table 4.10 provides detailed frequency and percentage.

#### Hypothesis 2:

*Null Hypothesis Two:* Education, counseling training, years of pastoral ministry, and size of church will have no significant influence upon Conservative Holiness pastors' ability to accurately assess for depression and willingness to refer to mental health professionals.

*Alternative Hypothesis Two:* Education, counseling training, years of pastoral ministry, and size of church will influence Conservative Holiness pastors' ability to accurately assess for depression and willingness to refer to mental health professionals. Specifically it is hypothesized that these variables, all related to exposure to mental health issues, will be positively correlated with ability to accurately assess for depression and willingness to refer to mental health professionals.

The null hypothesis was accepted for Hypothesis 2. Spearman's rho found that correlations between education, counseling training, years of pastoral ministry, and size of church were not statistically significant with diagnostic accuracy. Their willingness to refer to a mental health professional could not be analyzed due to the lack of variability

within the sample. More detailed output related to Diagnostic Accuracy is provided in Table 4.11.

Table 4.11

*Demographic variables and Diagnostic Accuracy*

	Diagnostic Accuracy
Education	.056
Counseling Training	.073
Years of Pastoral Ministry	-.112
Size of Church	-.059

Hypothesis 3:

*Null Hypothesis Three:* Attitudes toward mental health professionals and their services as well their Perceived Competency to assist those with depression will have no significant influence upon Conservative Holiness pastors' willingness to refer to mental health professionals.

*Alternative Hypothesis Three:* Attitudes toward mental health professionals and their services as well their Perceived Competency to assist those with depression will influence Conservative Holiness pastors' willingness to refer to mental health professionals. Specifically it is hypothesized that positive attitudes of mental health professionals and their services and high levels of perceived competency will be positively correlated with a willingness to refer to mental health professionals.

The third section of the questionnaire was also developed and used by Larson (1964, 1968), Lamberton (1992) and Azlin (1993). Terminology was updated and focused on depression. The thirty-three statements created three scales: Attitudes toward Mental Health Scale, Causes of Depression Scale; and Perceived Competency Scale. Each of the thirty-three statements were scored on a 5-point Likert scale from 1 (strongly agree) to 5 (strongly disagree).

Table 4.12

*Scale Means, Standard Deviations, and Reliability for Opinion Statements*

	<i>M</i>	<i>SD</i>	$\alpha$
Attitudes toward Mental Health Scale	28.41	5.24	.680
Perceived Competency Scale	25.18	7.87	.891

*Note:* On the Attitudes toward Mental Health scale, lower scores indicate better attitudes toward mental health professionals and their services. The range of possible scores on this scale is 19-50. On the Perceived Competency scale, lower scores indicate greater perceived competency to help those who are depressed. The range of possible scores on this scale is 9-45.

By analyzing the descriptive statistics, means and standard deviations were calculated for the Attitudes toward Mental Health Scale and the Perceived Competency scale. The reliability of these scales was determined by using internal consistency coefficients. Table 4.12 provides the means, standard deviations, and reliability for the Attitudes toward Mental Health scale and the Perceived Competency scale as each was used in this investigation.

Table 4.13

*Means and Standard Deviations for Agreement with Opinion Statements on the Attitudes toward Mental Health Scale*

Opinion Statement	Degree of Agreement	
	<i>M</i>	<i>SD</i>
The mental health practitioner's attitude toward the patient and his problem is for the most part a positive one.	2.55	1.01
On the whole, mental health practitioners are very competent.	2.71	1.13
In my opinion there are more "odd-balls" in psychiatry than any other profession. *	2.97	1.15
I feel that mental health practitioners overemphasize the sexual aspects of life as a cause of mental disorders. *	3.03	.83
Mental health practitioners are too evasive when it comes to facing a problem. *	3.04	.87
I have been greatly impressed by the results of psychiatric treatment.	3.16	.93
I feel the majority of emotional disturbances should be handled by the clergyman. *	3.30	1.28
Psychiatric treatment takes too much time and gets too poor results. *	3.40	.96
When you get right down to it, depressed parishioners should <u>not</u> be a clergyman's responsibility. Therefore, they should be referred to mental health practitioners. *	4.03	1.10
I feel the work of a mental health practitioner conflicts with the work of a pastor. *	4.05	1.08

*Note:* Means are from a 5-point Likert scale. Strongly agree = 1; Not Sure =3; Strongly disagree = 5. Items marked with an asterisk (\*) were reverse-coded in the computation of the scale scores.

Table 4.13 summarizes how the pastors responded to each of the statements found on the Attitudes toward Mental Health Scale. They appear in descending order from the highest level of agreement to the highest level of disagreement.

An independent t-test found that negative attitudes toward mental health were more frequent in those who were unwilling to refer to mental health professionals ( $t_{83}=3.125, p=.002<.01$ ). More detailed output is provided in Table 4.14.

Table 4.14

*Attitudes toward Mental Health (professionals and services) and Referral to Mental Health Professionals*

Referral to Mental Health Professionals	<i>n</i>	Attitudes toward Mental Health	
		<i>M</i>	<i>SD</i>
Willing to Refer	71	27.66	4.79
Unwilling to Refer	14	32.21	5.91

*Note:* On the Attitudes toward Mental Health scale, lower scores indicate better attitudes toward mental health professionals and their services. The range of possible scores on this scale is 19-50.

Table 4.15

*Means and Standard Deviations for Agreement with Opinion Statements on the Perceived Competency Scale*

Opinion Statement	Degree of Agreement	
	<i>M</i>	<i>SD</i>
I feel pretty competent and comfortable in talking with parishioners about their personal problems.	1.90	.90
Most depressed parishioners need more help than I can give. *	2.64	1.16
In general, I feel quite comfortable in caring for depressed parishioners.	2.73	1.21
I have a good understanding of how to help depressed parishioners.	2.85	1.21
My training and experience are such that I feel competent to take on most cases of depression among my parishioners.	3.17	1.33
I do not have the background to help depressed parishioners. *	3.18	1.24
I do not know what to do for many of my depressed parishioners. *	3.29	1.21
My training and experience in handling depressed parishioners are adequate.	3.44	1.29
My background severely limits my having much success with depressed parishioners. *	3.80	1.17

*Note:* Means are from a 5-point Likert scale. Strongly agree = 1; Not Sure = 3; Strongly disagree = 5. Items marked with an asterisk (\*) were reverse-coded in the computation of the scale scores.

Table 4.15 summarizes how the pastors responded to each of the statements found on the Perceived Competency Scale. They appear in descending order from the highest level of agreement to the highest level of disagreement.

The null hypothesis was partially accepted for Hypothesis 3. While the analysis in Table 4.14 demonstrated the significance of the association between Attitudes toward Mental Health professionals and services, the Pearson’s Product-Moment Correlation found that perceived competency to assist depression in parishioners was not correlated with diagnostic accuracy. Detailed output is provided in Table 4.16.

An independent t-test found no significant difference between those who would refer and those who would not refer to mental health professionals when it comes to perceived competency. ( $t_{82}=1.14, p=.257>.05$ ).

Table 4.16

*Perceived Competency and Diagnostic Accuracy*

	Diagnostic Accuracy
Perceived Competency	-.043

Hypothesis 4:

*Null Hypothesis Four:* Conservative Holiness pastors’ Recognition of Need for Help and their Confidence in Mental Health Professionals will have no significant influence upon their willingness to refer to mental health professionals.

*Alternative Hypothesis Four:* Conservative Holiness pastors' Recognition of Need for Help and their Confidence in Mental Health Professionals will influence their willingness to refer to mental health professionals. Specifically it is hypothesized that high recognition of need and high confidence in mental health professionals will be positively correlated with a willingness to refer to mental health professionals.

The fourth section of the questionnaire was developed by Fischer and Farina (1995). Items were revised consistent with research questions as they focus upon depression. The ten statements created two scales: Recognition of the Need for Help Scale and the Confidence in Mental Health Professionals Scale. Statements from each respective scale include: (a) I would want to get professional help if I were depressed for a long period of time; and (b) If I were experiencing serious depression at this point in my life, I would be confident that I could find relief in professional help. Each of the ten statements were scored on a 4-point Likert scale from 1 (strongly agree) to 5 (strongly disagree).

By analyzing the descriptive statistics, means and standard deviations were calculated for both of the scales. The reliability of these scales was determined by using internal consistency coefficients. Table 4.17 provides the means, standard deviations, and reliability for both scales.

Table 4.17

*Scale Means, Standard Deviations, and Reliability from the Attitudes Toward Seeking Professional Psychological Help: A Shortened Form*

	<i>M</i>	<i>SD</i>	$\alpha$
Recognition of the Need for Help Scale	11.49	3.33	.706
Confidence in Mental Health Professionals	8.27	2.40	.638

*Note:* On the Recognition of the Need for Help scale, lower scores indicate more acknowledgement of the need for help. The range of possible scores on this scale is 6-24. On the Confidence in Mental Health Professionals scale, lower scores indicate more confidence in mental health professionals. The range of possible scores on this scale is 4-16.

Table 4.18 summarizes how the pastors responded to each of the statements found on the Recognition of the Need for Help Scale. They appear in descending order from the highest level of agreement to the highest level of disagreement.

Table 4.19 summarizes how the pastors responded to each of the statements found on the Confidence in Mental Health Professionals Scale. They appear in descending order from the highest level of agreement to the highest level of disagreement.

The null hypothesis was accepted for Hypothesis 4. An independent t-test found no significant difference between those who are willing or unwilling to refer to mental health professionals in their scores for recognition of need for help ( $t_{84}=1.607$ ,  $p=.112>.05$ ) and confidence in mental health professionals ( $t_{82}=1.368$ ,  $p=.175>.05$ ).

Table 4.18

*Means and Standard Deviations for Agreement with Statements on the Recognition of the Need for Help Scale*

Statement	Degree of Agreement	
	<i>M</i>	<i>SD</i>
I would want to get professional help if I were depressed for a long period of time.	1.51	.72
I might want to have professional counseling in the future.	2.34	1.05
There is something admirable in the attitude of a person who is willing to cope with depression without resorting to professional help. *	3.17	.87
A person should work out his or her own problems; getting professional help would be a last resort. *	3.20	.79
Personal and emotional trouble, like many things, tend to work out by themselves. *	3.24	.81
Considering the time and expense involved in professional help, it would have doubtful value for a person like me. *	3.79	.98

*Note:* Means are from a 4-point Likert scale. Strongly agree = 1; Strongly disagree = 4. Items marked with an asterisk (\*) were reverse-coded in the computation of the scale scores.

Table 4.19

*Means and Standard Deviations for Agreement with Statements on the Confidence in Mental Health Professionals Scale*

Statement	Degree of Agreement	
	<i>M</i>	<i>SD</i>
A person with depression is not likely to get better alone; he or she is likely to get better with professional help.	1.65	.78
If I were experiencing serious depression at this point in my life, I would be confident that I could find relief in professional help.	1.94	.86
If I believed I was depressed, my first inclination would be to get professional attention.	2.77	1.01
The idea of treatment by a mental health professional strikes me as a poor way to get rid of emotional conflicts. *	3.10	.80

*Note:* Means are from a 4-point Likert scale. Strongly agree = 1; Strongly disagree = 4. Items marked with an asterisk (\*) were reverse-coded in the computation of the scale scores.

### Chapter Summary

A total of 86 questionnaires were analyzed for this study. Associations were found between the recognition of need for help and confidence in mental health with diagnostic accuracy. Associations were found between attitudes toward mental health and willingness to refer to a mental health professional. There were no statistically significant associations found between demographic variables and the two outcome variables.

Null Hypothesis 1 was rejected as it was found that Conservative Holiness pastors were willing and able to assess for depression. Null Hypothesis 2 was accepted as there was no indication that education, training, years of pastoral ministry, and size of church influenced ability to assess for depression while influence on willingness to refer to mental health professionals was unable to be tested. Null Hypothesis 3 was partially accepted as it was found that the higher the attitudes toward mental health professionals and services, the more willingness to refer to mental health professionals but that there was no indication that perceived competency influenced willingness to refer to mental health professionals. Null Hypothesis 4 was accepted as there was no indication that recognition of need for help or confidence in mental health professionals influenced willingness to refer to mental health professionals.

Chapter Five will summarize the study and present conclusion about the findings, limitations, implications for mental health professionals, and recommendations for future research.

## CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This study was carried out to measure whether Conservative Holiness pastors are willing and able to assess depression in their parishioners and what factors are associated with a willingness to refer depressed parishioners to mental health professionals. This chapter presents a summary of the study structure and methodology, characteristics of the participants and an interpretive summary of findings followed by limitations of the study, implications for mental health professionals, and recommendations for future research.

### **Research Questions**

This study included two distinct research questions and a total of five sets of hypotheses. The specific research questions addressed were:

1. Are Conservative Holiness pastors willing and able to assess depression in their parishioners?
2. What are the factors that are associated with Conservative Holiness pastors' willingness to consider referral to mental health professionals?

### **Summary of Study Measures and Procedures**

The instrument used in this study contained four parts. Part one was a demographic questionnaire that asked for participants to indicate their respective gender, age range, race, marital status, education level, college, counseling training, years of

pastoral ministry, denomination with which they are credentialed, church's denomination, and the attendance of the church they pastor. Part two was constructed in a manner proposed by Larson (1964, 1968). It was a collection of five case studies in which participants were asked to review the study and answer questions related to the severity of depression, the extent to which they could assist in treatment, to whom they would consider referral and the morality of the behaviors presented. Part three was a list of thirty-three opinion statements written by Larson (1964, 1968) and revised by Lamberton (1992) and Azlin (1993). The statements were refocused specifically to depression and related to participants' attitudes toward mental health, causes of depression, and their perceived confidence in providing assistance. Part four was the Attitudes Toward Seeking Professional Psychological Help: A Shortened Form (Fischer & Farina, 1995); it was used to measure recognition of the need for help as well as confidence in mental health professionals.

The instrument was administered during the three-day April 2012 Interchurch Holiness Convention in Dayton, Ohio. Pastors who self-identified as Conservative Holiness were invited to participate in the study in exchange for a free book. They were provided a pen and a self-sealing packet. The packet included an informed consent, the four-page instrument, and a note of thanks with instructions on returning the completed packet in exchange for the book. A total of 120 survey packets were distributed over the course of the convention; 86 were returned complete.

All pastors were eligible to participate provided that they self-identified as Conservative Holiness and were a senior pastor of a Conservative Holiness church. The

sample was almost exclusively male, almost exclusively white, and almost exclusively married. They represented twenty-two different denominational groups.

### **Summary of Findings**

Depression is the most frequently diagnosed psychiatric disorder (Craighead, Hart, Craighead, & Illardi, 2002). Religious people acknowledge that they are more likely to seek help from their pastor than from a mental health professional (Morgan, 1982) making pastors “front-line” responders (Weaver, Flannelly, Garbarino, Figley, & Flannelly, 2003, p. 217). Previous investigations have explored how age (Fulz, 2002), education and training (Fulz, 2002; Guinee & Tracey, 1997), denomination (Myers, 2000), and size of congregation (Gorsuch & Meylink, 1998; Mannon & Crawford, 1996) might influence this willingness to refer.

Mannon and Crawford (1996) found that pastors who self-identify as conservative are less likely to consider referring to mental health professionals. The Conservative Holiness Movement was chosen as the subject for this study because of their uniqueness: they hold to Wesleyan theological positions (Thornton, 1998) while also being linked to Fundamentalist practices as they relate to separation (Sidwell, 1999).

In this study, the willingness and ability to assess depression and the willingness to subsequently refer to mental health professionals was investigated in pastors who self-identify as Conservative Holiness. Frequency data was used to investigate willingness and ability to assess depression. Spearman’s rho, Pearson’s Product-Moment Correlation

and independent t-tests were used to analyze willingness to refer to mental health professionals.

Research question one inquired as to willingness and ability to assess depression. The findings were that Conservative Holiness pastors were indeed willing and able to assess depression. Differences in level of education, counseling-specific training, years of ministry, size of church, and perceived competence were found to not be associated with differences in their ability to accurately assess the severity of depression.

Research question two inquired as to the factors most associated with their willingness to refer to a mental health professional. The findings were that level of education, counseling-specific training, years of ministry, size of church, recognition of need for help, and confidence in mental health professions were found to not be associated with differences in their willingness to refer to mental health professionals. It was discovered that their attitudes toward mental health services and professionals did influence a willingness to refer. Agreement with statements related to professional care and competency were associated with a greater willingness to refer to mental health professionals.

## **Discussion**

This study found the demographic descriptors of the sample to be quite homogenous. The Conservative Holiness pastors who participated in the study were almost exclusively male, almost exclusively white, and almost exclusively married. While none of these factors are prerequisites to being a CHM pastor, there are few who

do not fit these sample characteristics. Nearly three-quarters of the participants (71%) attended one of the five largest Bible colleges founded as Conservative Holiness institutions. Due to the lack of variability, several demographic variables were not able to be analyzed as to their relationship to either outcome variable.

Consistent with previous studies (Linebaugh, 1981; Weaver, 1995), programs of study did not emphasize counseling. More than half of the pastors indicated that the highest academic degree earned was a bachelor's degree. More than half of them stated that their counseling training consisted of only one course or no course at all. The expected finding was that increased education and training would be associated with the ability to assess depression; this study did not establish that association most likely due to lack of variability in the sample.

The responses given to the specific scenarios provided some interesting findings. Pastors were most likely to refer someone they assessed as being mildly or moderately depressed to a pastoral counselor while they were likely to refer someone assessed as being severely depressed to a mental health professional. The group as a whole demonstrated a fair level of diagnostic accuracy. Their ability to discern was demonstrated in that the scenario that did not include symptomology consistent with depression was neither over-diagnosed nor over-referred.

One particularly salient note of concern relates to the scenario involving suicidal intent and plan as nearly one-fifth of pastors (19.6%) did not indicate that they would refer to a mental health professional and one pastor indicated that the scenario could address the situation without referring at all. There were thirteen pastors who never

indicated referral to a mental health professional. This refusal was found to be consistent with low confidence in mental health professionals, low recognition of need for help, and negative attitudes toward mental health.

Another finding of interest that has been consistent with other studies (Azlin, 1993; Lamberton, 1992) related to the pastors' desire to collaborate after referral. Most of the time, they endorsed that they could provide "some assistance" or "major assistance" even after referral to others. Combined with the high scores on the Perceived Competency scale, this indicates that pastors see themselves as able and willing to be an active part of the treatment.

### **Implications for Mental Health Professionals**

This study adds to the literature on pastoral referral to mental health professionals. Specifically, it indicates more willingness for pastors to collaborate with mental health professionals than in the past (Beck, 2002; Bland, 2003; Burgess, 1998; Edwards et al., 1999; McMinn, Chaddock, Edwards, Lim, & Campbell, 1998; McMinn, Meek, Canning, & Pozzi, 2001).

It is important that mental health professionals acknowledge that pastors are more than simply "gatekeepers" (McDonald, 1984). While ensuring that all legal and ethical protocol is being followed explicitly, mental health professionals should investigate clients' desire to have their pastor incorporated into treatment strategies, particularly if the pastor is the initial referral source. This study has underscored the idea that even

those pastors with minimal mental health-specific training have basic knowledge and a desire to help those on their pastoral purview.

In past studies, pastors have expressed concern about the religious views of mental health professionals (Mollica et al., 1986; Vespie, 2010; Wright, 1984). This may be one of the reasons why pastors in this study chose to refer cases to pastoral counseling rather than mental health counseling (McMinn et al., 2005). It may be wise for mental health professionals to be more open about their religious beliefs and how they inform their view of counseling.

Mental health professionals should seek out opportunities to interface directly with local pastors for two distinct purposes. First, positive interactions between mental health professionals and pastors will help to minimize the demonstrated hesitancy to refer (Gardner, 2013; Gilbert, 1981; Meylink & Gorsuch, 1988). Second, pastors should be affirmed for their desire for additional training on these issues (Weaver et al., 2002). Mental health professionals should provide resources for pastors in recognition for their important role in the process of providing effective treatment to people of faith (Vespie, 2010). In this study, the variable that was statistically significant with a willingness to refer related to the pastor's attitudes about mental health treatment and providers. Intentionally addressing that component may result in an increase in appropriate referrals.

### **Recommendations for Future Research**

The population in focus for this study, Conservative Holiness pastors, demonstrated a significant degree of homogeneity; variability was limited and that

negatively influenced the ability to complete advanced statistical analysis. Future studies may concentrate on religious groups with more variability in order to analyze the differences.

In this study, more than half of the participants did not receive educational training beyond a bachelor's degree. With the changing face of mental health services, a study of interest would first include a training opportunity for pastors providing an overview of depression or another psychiatric diagnosis. Future research that includes pre- and post-test assessments with a training treatment variable would demonstrate the immediate effectiveness of additional training.

This study concentrated on hypothetical scenarios and a pastor's ability to assess and willingness to refer. Further research should seek to follow-up to see if this degree of willingness to refer results in actual referrals – and how a positive or negative outcome influences future referral willingness. Such an investigation could also seek to inquire about how the pastor perceived the willingness of the mental health professional to see their relationship as a collaborative one.

Pastors have local jurisdictions and mental health providers are specific to those local areas. Further research might focus on a pastor's awareness of local resources and how a pastor identifies a mental health professional in their respective area.

On a research design level, future research might benefit from a mixed-method approach in which individual pastors are also interviewed as a means of gathering a greater depth of understanding as to the reasons behind some of their responses.

## **Limitations**

The use of case study vignettes can be an effective strategy but it should be noted that it may be that different vignettes could yield different responses. Inherent with self-report surveys are concerns that participants would seek to demonstrate competency and augment answers based upon what they believed the correct answer to be.

Since the literature uses a number of terms to describe similar constructs, this study simplified a number of key terms. It may be that taking the time and space to clarify the differences among mental health professionals (psychologists, psychiatrists, clinical social workers, psychiatric nurses, marriage and family therapists, and licensed professional counselors) would yield different results.

The study data was collected during the April 2012 Interchurch Holiness Convention, the largest gathering of Conservative Holiness pastors (Kostlevy, 2009). However, it may be that the 86 pastors who chose to participate are not representative of all Conservative Holiness pastors. Participants were attending an interchurch convention which perhaps indicates a greater willingness to collaborate with others.

Sample size for this study was smaller than anticipated and desired. The attendance of the April 2012 convention had declined from previous years. It was speculated that this may have been due to rising costs of attending the conference and travel. Similarly, it was noted that more convention attendees stayed outside of the on-site convention hotel meaning that more time was spent in travel and parking than viewing the exhibitors' area where the survey was administered.

While it has been noted that Conservative Holiness pastors can be conceptualized as Wesleyan in theology and Fundamentalist in practice, it should not be assumed that this study can be generalized to either groups. More mainline Wesleyan churches do not have the same component of separation as CHM churches while Fundamentalist churches include the separation component but do not ascribe to a Wesleyan approach to Scripture and God's created order.

This study was initially conceptualized as an investigation of view of mental health treatment in general. Later it was decided to focus specifically on depression. It may be that pastors' views would change if the identified "presenting problem" were to be anxiety, substance abuse, schizophrenia, or another psychiatric disorder.

A clear factor in pastor's willingness to refer has been their comfort level in knowing that the mental health professional had beliefs consistent with their own (Clark & Thomas, 1979; Dougherty & Worthington, 1982; Gass, 1984; King, 1978). Since the investigator in this study is known within the Conservative Holiness Movement as a mental health professional, they may have been answering responses with a specific individual in mind – an individual who shares their theological perspectives. The announcements distributed during the convention clearly identified the investigator and noted the investigator's credentials as a Licensed Professional Counselor. Pastors in attendance who have a more hostile view of mental health professionals may have avoided participation for this reason.

## Chapter Summary

This study sought to investigate Conservative Holiness pastors' willingness and ability to assess depression and their willingness to refer to mental health professionals for the treatment of depression. This group was chosen because of their unique perspective of being both Wesleyan and Fundamentalist. This being a homogenous group resulted in the fact that several of the variables were unable to be tested due to a lack of variability.

A review of frequency data did reveal both a willingness to assess depression and the ability to do so with some accuracy. Pastors were more willing to refer to mental health professionals than anticipated and most often identified a clinically appropriate referral choice based upon the severity of the scenarios presented. A significant finding related to the correlation between attitudes toward mental health and a willingness to refer to mental health professionals.

These findings indicate that mental health professionals should seek to interface more with pastors – even those traditionally viewed as being closed to considering referring to professionals for counseling. This collaboration should relate both to the appropriateness of referral to treatment and the education of how pastors can play a valuable part in that process.

A number of directions for future research were proposed; one that would be particularly salient given these findings would be to investigate how many Conservative Holiness pastors really do actively make referrals to mental health professionals and their reflections on the efficacy of the current process.

Limitations of this study and its generalizability to groups and scenarios outside of this specific sample at this specific moment in time were disclosed.

### **Study Summary**

Depression has been referred to as “the common cold of mental illnesses” (Rosenhan & Seligman, 1995, p. 307). It interferes with daily functioning and relationships (Lastoria, 1999) and yet many avoid seeking treatment (Brown & Bradley, 2002). Those that do seek treatment often turn to their pastor for guidance (Gurin, Veroff, & Feld, 1960; McMinn et al., 2006; Veroff, Kulka, & Douvan, 1981).

Vespie (2010) has noted that conservative pastors of other theological perspectives “vilify psychological and secular counseling as evil and something to be avoided” and “may discourage professional counseling from the pulpit” (p. 90). While Conservative Holiness pastors would be just as “conservative” in their practice of their faith as other groups, this study demonstrates that on this issue, they are more willing to collaborate and refer with mental health professionals – even if the religious faith of the mental health professional is not explicitly disclosed.

Mental health professionals should reach out to Conservative Holiness pastors in an effort to both facilitate more advanced training on issues related to mental health and depression and as a means of facilitating greater collaboration in the treatment of those with psychiatric disorders.

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All **Conservative Holiness** pastors who



are **actively pastoring**

Conservative Holiness churches  
are invited to participate in a doctoral  
research study on **Depression.**

The **survey** should take just **10 to 20** minutes

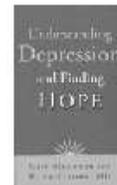
to complete and is completely **anonymous.** It relates to

your views on depression and your response as pastor.

In return for your time, the first **130** pastors will have



their choice of a **free book.**



Please stop by my booth to participate or to ask questions.

**Andrew Graham**

APPENDIX B: Invitation/Announcement in IHC Program

Conservative Holiness pastors who are actively pastoring Conservative Holiness churches are invited to participate in a doctoral research study on Depression.

The survey should take just 10 to 20 minutes to complete and is completely anonymous. It relates to your views on depression and your response as pastor. In return for their time, the first 130 pastors will have their choice of a free book.

Please stop by my booth to participate or to ask questions.



**ANDREW J GRAHAM**  
LICENSED PROFESSIONAL  
COUNSELOR  
[CHRISTIANCOUNSELINGADVICE.COM](http://CHRISTIANCOUNSELINGADVICE.COM)

## APPENDIX C: Consent Form

### CONSENT FORM

**Perspectives on Depression among Conservative Holiness Pastors**  
**Andrew J Graham, MA, LPC**  
Liberty University  
Center for Counseling

You are invited to be in a research study of Conservative Holiness Pastors and their perspectives on depression. You were selected as a possible participant because you are a pastor who identifies as Conservative Holiness who is actively pastoring a church that identifies as Conservative Holiness. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: **Andrew J Graham, MA, LPC – Center for Counseling – Liberty University.**

#### **Background Information**

The purpose of this study is to examine the perceptions of Conservative Holiness pastors towards depression.

#### **Procedures**

If you agree to be in this study, we would ask you to do the following things: Take the survey packet and pen, complete each item, and return the packet to the display area before leaving IHC. You can take your completed survey, seal it in the envelope and place it in the box.

The survey should take between 10 and 20 minutes to complete.

#### **Risks and Benefits of being in the Study:**

While no study is without risk, the risks associated with this study are no more than would be encountered in everyday life. The survey questions may be associated with an increased awareness of depression-related topics which may result in some minor emotional discomfort. I am available to discuss any discomfort you may experience.

The benefits to participation are that we will have a better understanding of the perceptions of Conservative Holiness pastors towards depression.

#### **Compensation**

You will receive reimbursement in the form of your choice of two books available at the IHC display table. Books will be distributed in return for a completed form.

#### **Confidentiality**

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a subject. Research records will be stored securely and only researchers will have access to the records. In this study, privacy will be protected by the fact that no identifying information will be on the survey.

#### **Voluntary Nature of the Study**

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

#### **Contacts and Questions**

The researcher conducting this study is Andrew J Graham, MA, LPC. You may ask any questions you have now. If you have questions later, you are encouraged to contact Andrew at 111 Berkshire Place, Lynchburg, VA, 24502; (434) 515-2012; [ajgraham@liberty.edu](mailto:ajgraham@liberty.edu). Andrew's advisor for this doctoral dissertation project is Dr. Fred Milacci; (434) 592-4043; [fmilacci@liberty.edu](mailto:fmilacci@liberty.edu).

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), you are encouraged to contact the Institutional Review Board, Dr. Fernando Garzon, Chair, 1971 University Blvd, Suite 1582, Lynchburg, VA 24502 or email at [fgarzon@liberty.edu](mailto:fgarzon@liberty.edu).

***A copy of this information has been provided in the survey packet.***



**CASE THREE:** Mrs. Smith is in her early sixties. She has lost 25 pounds in the last 2 months though she hasn't been trying to. She doesn't feel like eating and finds herself sleeping most of the day. Since her husband's death last year, she says that she no longer has anything to wake up for. She feels sad all the time. Her doctor has found nothing wrong with her physically.

To what extent is Mrs. Smith depressed?

- There is no evidence of depression.
- There is evidence of mild depression.
- There is evidence of moderate depression.
- There is evidence of severe depression.

Is there anyone to whom you would recommend that Mrs. Smith go?

- No
- Another pastor
- Family physician
- Pastoral counselor
- Mental health professional

To what extent could you help Mrs. Smith?

- I could handle the case alone. I have adequate training to handle cases of this sort.
- I could provide major assistance in conjunction with properly trained professional people.
- I could provide some assistance in conjunction with properly trained professional people.
- I am not adequately trained to handle cases of this sort other than to refer to professional people.

Is Mrs. Smith responsible for doing anything immoral?

- Yes
- Not sure, undecided
- No

**CASE FOUR:** Mr. Williams is in his early-thirties. He is married with a young son but he and his wife have recently separated and she and their son have moved out. Since they left, he has lost all interest in his normal activities; he recently began giving away some of his possessions. He says that "life isn't worth living" anymore since he feels as though his family and God have turned their back on him. He says that he has a gun and that after saying goodbye to his son, he plans to shoot himself in the head.

To what extent is Mr. Williams depressed?

- There is no evidence of depression.
- There is evidence of mild depression.
- There is evidence of moderate depression.
- There is evidence of severe depression.

Is there anyone to whom you would recommend that Mr. Williams go?

- No
- Another pastor
- Family physician
- Pastoral counselor
- Mental health professional

To what extent could you help Mr. Williams?

- I could handle the case alone. I have adequate training to handle cases of this sort.
- I could provide major assistance in conjunction with properly trained professional people.
- I could provide some assistance in conjunction with properly trained professional people.
- I am not adequately trained to handle cases of this sort other than to refer to professional people.

Is Mr. Williams responsible for doing anything immoral?

- Yes
- Not sure, undecided
- No

**CASE FIVE:** Mr. Jones is in his mid-fifties. He is married with two teenage children. He was laid-off from his full-time job three months ago and has been unable to find steady work. He is having difficulty sleeping at night and is fatigued throughout the day. He says that he feels worthless because he has been unable to provide for his family.

To what extent is Mr. Jones depressed?

- There is no evidence of depression.
- There is evidence of mild depression.
- There is evidence of moderate depression.
- There is evidence of severe depression.

Is there anyone to whom you would recommend that Mr. Jones go?

- No
- Another pastor
- Family physician
- Pastoral counselor
- Mental health professional

To what extent could you help Mr. Jones?

- I could handle the case alone. I have adequate training to handle cases of this sort.
- I could provide major assistance in conjunction with properly trained professional people.
- I could provide some assistance in conjunction with properly trained professional people.
- I am not adequately trained to handle cases of this sort other than to refer to professional people.

Is Mr. Jones responsible for doing anything immoral?

- Yes
- Not sure, undecided
- No

**PART III (continued) – Circle the best answer to each question.**

24. Depression is learned.	Strongly Agree	Partly Agree	Not Sure	Partly Disagree	Strongly Disagree
25. The mental health practitioner's attitude toward the patient and his problem is for the most part a positive one.	Strongly Agree	Partly Agree	Not Sure	Partly Disagree	Strongly Disagree
26. In my opinion there are more "odd-balls" in psychiatry than any other profession.	Strongly Agree	Partly Agree	Not Sure	Partly Disagree	Strongly Disagree
27. Depression is inherited.	Strongly Agree	Partly Agree	Not Sure	Partly Disagree	Strongly Disagree
28. I have a good understanding of how to help depressed parishioners.	Strongly Agree	Partly Agree	Not Sure	Partly Disagree	Strongly Disagree
29. I feel that mental health practitioners overemphasize the sexual aspects of life as a cause of mental disorders.	Strongly Agree	Partly Agree	Not Sure	Partly Disagree	Strongly Disagree
30. A run-down physical condition is a cause of depression.	Strongly Agree	Partly Agree	Not Sure	Partly Disagree	Strongly Disagree
31. Most depressed parishioners need more help than I can give.	Strongly Agree	Partly Agree	Not Sure	Partly Disagree	Strongly Disagree
32. I have been greatly impressed by the results of psychiatric treatment.	Strongly Agree	Partly Agree	Not Sure	Partly Disagree	Strongly Disagree
33. Sex habits are a cause of depression.	Strongly Agree	Partly Agree	Not Sure	Partly Disagree	Strongly Disagree

**PART VI – Circle the best answer to each question.**

1. If I believed I was depressed, my first inclination would be to get professional attention.	Agree	Partly Agree	Partly Disagree	Disagree
2. The idea of treatment by a mental health professional strikes me as a poor way to get rid of emotional conflicts.	Agree	Partly Agree	Partly Disagree	Disagree
3. If I were experiencing serious depression at this point in my life, I would be confident that I could find relief in professional help.	Agree	Partly Agree	Partly Disagree	Disagree
4. There is something admirable in the attitude of a person who is willing to cope with depression without resorting to professional help.	Agree	Partly Agree	Partly Disagree	Disagree
5. I would want to get professional help if I were depressed for a long period of time.	Agree	Partly Agree	Partly Disagree	Disagree
6. I might want to have professional counseling in the future.	Agree	Partly Agree	Partly Disagree	Disagree
7. A person with depression is not likely to get better alone; he or she is likely to get better with professional help.	Agree	Partly Agree	Partly Disagree	Disagree
8. Considering the time and expense involved in professional help, it would have doubtful value for a person like me.	Agree	Partly Agree	Partly Disagree	Disagree
9. A person should work out his or her own problems; getting professional help would be a last resort.	Agree	Partly Agree	Partly Disagree	Disagree
10. Personal and emotional trouble, like many things, tend to work out by themselves.	Agree	Partly Agree	Partly Disagree	Disagree

## APPENDIX E: Thank You Letter

### THANKS!

Thanks for consenting to participate in my study of Conservative Holiness Pastors and their perspectives on depression.

#### Procedure

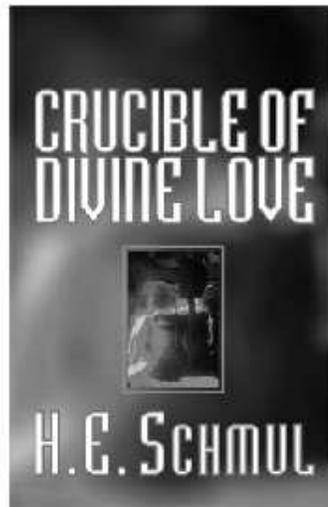
Please return the packet to the display area before leaving IHC. You can take your completed survey, seal it in the envelope and place it in the box.

#### Compensation

You will receive reimbursement in the form of your choice of two books available at the IHC display table. Books will be distributed in return for a completed form.

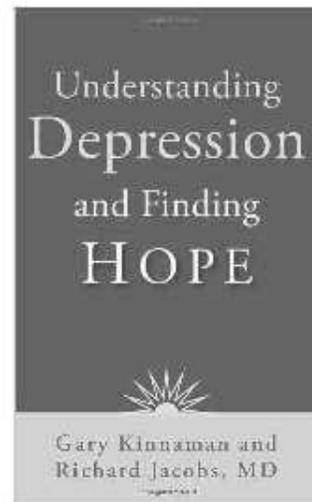
#### Book Choices

(while supplies last)



Retail Value: \$ 7.99

The author frequently referred to the Christian life in terms of refining fire—unpleasant, hot, but necessary to distill a treasure's purity. Captures his powerful love for souls and asserts that holy people still have weaknesses, failures and flaws that need the redemptive work of the blood of Jesus and the purging fire of the Holy Spirit. "H.E. Schmul at full throttle!"



Retail Value: \$ 5.99

Written by a pastor and a medical doctor who have been personally impacted by depression, this book confronts the myths that have developed around the disease and offers strategies for every area of life—physical, psychological, and spiritual—that it touches. A great resource for those who give counsel and support to others—pastors, counselors, small group leaders, teachers, concerned friends, and family members.

Andrew J Graham MA LPC  
christiancounselingadvice@gmail.com  
christiancounselingadvice.com  
(434) 515-2012