EXPERIENCES AND PERCEPTIONS OF PASTORS IN MINISTERING TO
CONGREGANTS WITH MENTAL ILLNESS

A Project

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by
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Donelle Swain

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Division of Social Work
Abstract

of

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Many studies prove that people seek out their pastors first when experiencing a mental health crisis; however, there is a lack of studies showing how pastors minister to those experiencing a mental health crisis. This study uses qualitative interviews of 11 pastors in the Northern California region to gain an understanding of their experiences and perceptions in ministering to congregants with mental illnesses. This study found that pastors desire to play a supporting role in the lives of their congregants with a mental illness, to help break stigma that exists around mental illness in the church, that they were not properly prepared to work with a congregant with a mental illness, and that there is a lack of collaboration between pastors and mental health professionals. These findings can affect future policy and practice surrounding regulations for pastors working with mentally ill congregants.

_______________________, Committee Chair
Dr. Jennifer Price Wolf

_______________________
Date
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Chapter 1

INTRODUCTION

The National Survey on Drug Use and Health defines a person suffering from a mental illness as someone presenting with a mental, behavioral, or emotional disorder that can currently be diagnosed and meets diagnostic criteria specified within the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). The United States has the highest rate of mental health diagnosis among developed nations (Vanderwaal, Hernandez, & Sandman, 2012; World Health Organization, 2005). An estimated 43.7 million adults in the United States are diagnosed with a mental illness, which represents 18.6% of all United States adults (National Alliance on Mental Illness, 2015; Polson & Rogers, 2007). Within a given 12-month period, more than 25% of Americans meet the criteria for a psychiatric disorder (Pierre, 2012). Additionally, it was reported that about 20% of children in the United States have, at some point, been diagnosed with a mental illness (World Health Organization, 2005). Being diagnosed with a mental illness leaves you at risk for job loss, homelessness, dropping out of school, losing your independence, relationship issues, and many other negative side effects.

Although statistics vary, approximately 70-80% of persons in the United States attend church regularly (Polson & Rogers, 2007; Wood, Watson, Hayter, 2011). It is not surprising, then, that when an individual is confronted with a mental health crisis they are more likely to seek help from church leadership over any other professional (Bledsoe, Setterlund, Adams, Fok-Trela, & Connolly, 2013; Bornsheuer, Henriksen, &
Irby, 2012; Leavey, Dura-Vila & King, 2011; Oppenheimer, Flannelly, & Weaver, 2004; Stanford, 2007). Church leaders are often first responders to an individual struggling with a mental illness (Bornsheuer et al., 2012; Oppenheimer et al., 2004; Polson & Rogers, 2007; Vanderwaal, 2012; Wood et al., 2011), and often are the only professionals available in rural and poorer communities providing mental health services. This is due to a lack of resources and inadequate health insurance (Wood et al., 2011).

According to a study done by Lifeway Research, 59% of pastors have counseled someone who would eventually be diagnosed with a mental illness but only 38% of pastors feel equipped to identify a person dealing with a mental illness (2014). Furthermore, according to Albers, Meller, and Thurber (2012), religious caregivers of the mentally ill have little basic information regarding mental illness.

Historically, religious traditions have not cultivated a compassionate disposition toward those with mental illness (Albers et al., 2012). According to LifeWay Research’s study, “New Study of Acute Mental Illness and Christian Faith” (2014), 65% of family members of someone with a mental illness think churches should talk about mental illness more openly so that it is no longer considered a taboo topic. However, according to the same study, 49% of pastors rarely or never speak to their congregation regarding mental illness. The study done by Lifeway Research shows that it is clear there is a desire among congregants to have their pastors speak about mental health more frequently; therefore, it is important that pastors be educated about this topic. However, 66% of pastors have only read books on counseling people with mental illness.
Thus showing the minimal formal training pastors have on this topic. The skills needed for treating those with a mental illness cannot be learned from reading a book. Practical and supervised counseling experience is needed in order to gain the skills to counsel appropriately and effectively (Collins, 2007).

Additionally, family members of someone with a mental illness, as well as individuals with a mental illness, agree that churches have a responsibility to provide resources and support to those with mental illness and their families (Smietana, 2014). In light of this, it is critical that religious leaders are properly trained and equipped with resources in how to respond to and support individuals and families of individuals experiencing a mental health crisis. Seminary courses on mental illness are rare, though the subject of mental illness comes up frequently in pastoral care (Capps, 2012). Due to this, it is important that pastors have access to appropriate educational resources to further their knowledge and limitations on this topic. It would be useful for pastors to refer individuals in crisis to mental health professionals and for mental health professionals to establish collaborative relationships with pastors in order to best help their clients (Oppenheimer et al., 2004). Collaboration, although important, remains difficult. In many churches the topic of mental illness is still taboo, which stems from the negative influence of the anti-psychiatry movement in the 1960s and 1970s (Stanford, 2007). A religious support system plays a vital role in recovery and prevention of mental illness (White et al., 2003). By understanding the training and educational needs of pastors working with people suffering from mental illnesses, this study seeks to reduce the secrecy, shame, and silence inflicted upon those who are
suffering from mental illness (Albers et al., 2012), educate pastors on how to better equip themselves to counsel, and help pastors realize their counseling limitations and the importance of referring to a professional therapist.

There are many studies that prove that people seek out their pastors first when experiencing a mental health crisis as well as studies that show that when persons of faith include their spirituality as part of their treatment they have better outcomes. However, there is a lack of studies showing how pastors view the services they provide to congregants with mental health disorders, the experiences of pastors ministering to congregants with mental health disorders, pastors perceptions of mental illness, and the perceived training or resource needs of pastors working with congregants who have mental illness.

**Purpose of Study**

This study explores these topics by using in-depth qualitative interviews of pastors who attend to persons with mental illnesses. This study is important because if pastors do not know when to refer to professional counselors or are better equipped with better training to work with those with mental illness congregants could suffer due to pastors lack of recognition of their limitation. This is important to the social work field because if pastors are counseling without proper training, it could be detrimental to the consumers as well as to the larger community (Polson and Rogers, 2007). In-depth interviews will be conducted with pastors in Northern California to determine the types of training and education that pastors have, as well as the perception pastors have of mental illness and individuals struggling with a mental illness. This study will also seek
to find whether pastors have found successful ways to collaborate with secular counselors and what barriers they faced in collaboration.

**Theoretical Framework**

Our research seeks to answer questions about the perceptions, experiences, and service needs of pastors working with congregants with mental illness, as well as to explore their connection to, and collaboration with, the larger mental health community. What inspired this research is the pursuit of a deeper understanding of how mental illness is conceptualized by pastors who are described in the literature as first responders (Bornsheuer et al., 2012; Nichols & Hunt, 2011; Oppenheimer et al., 2004; Polson & Rogers, 2007; Vanderwaal, 2012; Wood et al., 2011). Systems theory provides the theoretical framework for this inquiry.

What is loosely called systems theory today has its intellectual origins in both sociology and biology (Robbins, Chatterjee, & Canda, 2011). The systems approach stems from “general systems theory,” developed by the biologist Ludwig Von Bertalanffy in 1928, which asserts that there are universal principles of organization that hold true for all systems (Mizikasi, 2006). The primary principles of systems theory are that the whole is greater than the sum of the parts, the whole determines the nature of the parts, and the parts are interconnected and must be understood in relation to the whole (Mizikasi, 2006). According to Banathy, systems have four main characteristics: a) systems are goal oriented, b) systems have inputs from their environment, c) systems have outputs to achieve their goals, and d) there is feedback from the environment about the output (as cited in Mizikasi, 2006).
Human social systems are analogous to biological systems in certain respects. In the same way that social systems attempt to survive through adaptation and self-preservation and are interrelated and interdependent, human systems and their environments are intricately connected to one another (Robbins et al., 2011). Systems theory helps us understand the interactions between individuals, groups, organizations, communities, larger social systems, and their environments.

When considering a mentally ill congregant in the context of his or her church, it is important to “zoom out” to develop a holistic and relational view of the person in their larger environment. When one considers the pastor as a frontline mental health worker attempting to help a congregant of their church cope or recover from a mental illness, collaboration with that individual’s larger support system would be considered what Von Bertalanffy (1968) called an “open system.” This is a system that receives input from the environment as well as releases output to the environment. As Von Bertalanffy (1968) points out:

there are many instances where identical principles were discovered several times because the workers in one field were unaware that the theoretical structure required was already well developed in some other field. General systems theory will go a long way towards avoiding such unnecessary duplication of labor. (p. 33)

This is a salient point in considering pastor’s and mental health professionals’ willingness and ability to collaborate on behalf of the congregant, in order to not duplicate or conflict their efforts. For example, mindfulness and meditation are
secular interventions used by mental health professionals; however prayer is another form of meditation that could serve the identical function that both pastor and professional are seeking for the congregant. A collaborative approach would complement each intervention rather than contradict or duplicate them.

Focusing on the interrelatedness of people and their environments, as well as their interactions with and adaptations to one another, is the essence of systems theory. Although pastors function from a more theological rather than theoretical framework, a keen grasp of systems theory could inform a pastor of the contextual nature of human behavior when counseling a congregant suffering from a mental illness.

A collaborative approach could prove to be extremely useful for pastors who are seeking to work with secular mental health professionals to “connect the dots” with their congregant for a more holistic approach to coping with and recovering from a mental illness. The pastor could then minister to the congregant with the broader goal of wholeness and healing, in conjunction with mental health professionals, assimilating the congregant into the church community. Collaboration is key to the healing of the mentally ill person. For effective collaboration to occur, pastors need to be well informed of the resources in their community.

Systems interactions affect pastors and congregants as well as society as a whole. As churches seek to reduce stigma for mentally ill congregants, the individuals will stand to be positively impacted. Pastors could be accountable by their church members being more candid about their diagnoses or their personal struggles, leading to more referrals to mental health professionals. Society would ultimately benefit from these
systems working together more seamlessly as there could be a more informed and professional understanding of the mentally ill, and more of a holistic approach to healing.

Systems theory envisions pastors as one component of a system of care for the congregant. An individual pastor may not be able to address all relevant aspects of the person and environment, therefore systems theory supports collaborative work with other professionals who specialize in a variety of areas. In addition, pastors may identify other formal and informal support systems that create a comprehensive systems approach. Viewing the pastor/congregant relationship through this theoretical lens would allow for a more holistic approach to coping with and recovering from a mental illness.

**Theological Framework**

Theology and psychology intersect at the very point they also diverge—core beliefs about human nature. Christian pastors vary in their interpretations of scripture; however, their approach to counseling is informed by the Bible rather than the Diagnostic Statistical Manual (DSM). Whereas mental health professionals practice from multiple theoretical frameworks, pastors are trained to function from a biblical counseling model which is informed by their theology. Christian theology teaches that individuals are created in the image of God (Genesis 1:27, New Living Translation), that people have infinite worth and value (Psalm 139:13, New Living Translation; Ephesians 1:13, New Living Translation), and that sin is what impedes our growth and full
potential as human beings (John 1:8, New Living Translation; Romans 3:23, New Living Translation).

In Christian theology, the problem of human nature could be summed up in one word: sin (Park, 2015). The problem of sin is central for the Christian pastor in addressing human behavior. For pastors, healing (or recovering from a severe mental illness) is not solely about finding the correct medication or intervention to address a mental disorder. The Christian approach would incorporate finding the root cause of the disturbance, which would include exploring attitudes and choices of the congregant that might be considered sinful.

While not all Christian pastors see mental illness as a result of sin, most see it as part of our “fallen” nature, and sin is the result of the fall of mankind. One pastoral counseling professor sums up the anthropological factors that underlie pastoral care and counseling from a Christian perspective as focusing on the nature of the human, the nature of sin, and the nature of reconciliation (Oglesby, 1979).

In modern psychology, the idea of “self” has largely replaced the theological concept of the “soul.” When looking at mental illness, it is important to draw distinctions between how a secular psychologist might frame the problem versus a Christian pastor. The idea that each person is accountable to God is uniquely biblical and informs a pastor’s approach to counseling a mentally ill congregant. In the secular worldview of the “self,” God becomes peripheral in understanding mental illness and is used as a means of self-improvement, while psychiatrists are viewed as experts.
Unlike postmodern humanistic psychology, Christian theology teaches that there is only one God and one way to achieve eternal life, through redemption and forgiveness of sins by the sacrifice of Jesus Christ on the cross. Christian pastors, then, are working from a philosophical and therapeutic lens that is reductionist in nature and often at odds with humanistic psychology. Eric Johnson (2007) asserts that the “Bible contains what might be called the first principles of soul care—the most important truths for the maturation of the soul—and so it provides the God-breathed foundation for a radically Christian model of soul healing” (p. 119). Mental illness, then, is not solely a chemical imbalance, but rather a spiritual issue with broader implications for the individual. The theological lens puts God squarely in the center, rather than the individual. A Christian pastor will strive to help the suffering congregant to find God at the center of their suffering. This theological framework is helping for understanding how pastors approach their work with congregants expressing symptoms of mental illness.
Chapter 2

LITERATURE REVIEW

This chapter will begin by describing the history between faith communities and the mental health community and will be followed by a review of the literature regarding current issues currently facing the faith community as it intersects with those experiencing mental illness. Subtopics to be examined include pastors as frontline mental health workers, the effectiveness of Christian counseling, pastoral counseling, the education of ministers, and collaboration efforts between secular counselors and pastors.

History of Mental Illness and the Church

History shows us that the Christian church and mental health have not always worked well together. Despite this, it is clear that for a religious person to be able to fully recover from or cope with a mental illness they must incorporate their whole self, including their religious beliefs. As a result, it is important that the Christian church begin to have a better understanding of mental illness and the psychiatric world. The purpose of this chapter is to review existing literature on the topic of mental illness and the church. This chapter considers research that evaluates pastors’ perceptions and knowledge on this topic and what congregants want and expect from their pastors. While reviewing the literature, the investigators will begin to develop a better understanding of what is missing from the field and to formulate a study that will benefit this population.
Pre-Enlightenment Era

Mental illness can be identified as far back as ancient Egypt when an Egyptian God is described as having symptoms of a mental illness (Albers, Meller, & Thurber, 2012). Some theologians and scholars argue that mental illness can be seen in the Bible. For example, in gospel of Mark 5:1-20, a man displays what could be described as a psychotic episode while being possessed by demonic powers (Albers et al., 2012). Collins (2007) writes that symptoms of depression can be found throughout the Bible including in the book of Psalms, and the biblical stories of King David, Job, Moses, Jonah, Peter, the nation of Israel, and even Jesus in Gethsemane. Additionally, some say Jesus encountered many individuals with mental and emotional illnesses in upper Galilee (Capps, 2012). Jesus, who is the divine Christian example of how to live, spent many hours speaking to people who struggled. The apostle Paul was sensitive to the needs of those who were hurting, writing that the strong must bear the weakness and help carry the burdens of those who are weak. The Bible does not present helping people as an option but as the responsibility of every believer (Collins, 2007). For example, in the gospel of Matthew, Jesus says, “Whatever you do to the least of these, you have done unto me” (Matthew 25:40, New Living Translation). In reality, however, individuals with mental illness are often cast aside by society, including within the Christian church, as they are frequently misunderstood and therefore ostracized.

History shows that those suffering from mental illnesses were more often than not seen as the outcasts of society, frequently being sent to private homes or institutions and unable to interact with society (Albers et al., 2012). The continued stigma that
surrounds mental illness has, both in the past and sadly still today, lead to violent
treatment of those suffering from mental illness. Before mental illness had been
medically defined, persons of religion often thought that sufferers may be demon
possessed and would use exorcism as a form of treatment during the biblical era (Albers
et al., 2012). The story of the Galilean man purportedly possessed by demons recounted
in the gospel of Luke 8:26-35 shows the Christian view of mental illness as something to
be feared, shunned, and/or exorcised (Anderson, Zuehlke, & Zuehlke, 2000). Tension
between religion and psychiatry dates back to the Enlightenment period of the 17th and
18th centuries, when scientific and rational theories began to compete with religion in
explaining the world (Bristow, 2011). Before then, it was difficult to distinguish religion
from medicine. Any serious attempt at communication between the mental health
community and the faith community must first look at the history of their perceptions of
each other (Sullivan et al., 2014).

Modern and Post-Enlightenment Era

Many of the founding fathers of psychiatry had an interest in religion (Whitley,
2012). Jaspers and Jung attempted to integrate psychiatry and religion (Jaspers, 1971;
Jung, 1963), while Sigmund Freud, B.F. Skinner, and Albert Ellis were vocally
antireligious. Freud even wrote that religion was a narcotic and an illusion (Collins,
2007). The secular view of these latter pioneers of mental health alienated many people
of faith, as the church viewed their scientific methods similarly to evolution and felt the
medicalization of mental health gradually devalued pastors (Sullivan et al., 2014). Some
pastors felt threatened and marginalized by this new framework. The rise of modern
science, medical reasons for behavior, and the fields of psychology and psychiatry drove a wedge between the church and science with regard to mental health, and resulted in increased tension between “spiritual” and science-based understanding of mental and emotional well-being (Fulford, 1997).

Conflict between religion and mental health emerged during the rise of Enlightenment thinking and the subsequent Darwinian and Freudian revolutions, which intensified the debate between matters of the soul, mind, and body (Reed, 1997). Although religion and mental health have not always seen eye-to-eye, religious leaders began seeing a connection between spiritual and emotional well-being in the early 1900s. Reverend Anton Boisen, founder of the Clinical Pastoral Education movement, began using supervised contact of patients diagnosed with a mental health disorder as a part of his theological training of students. This program brought disciplined training to the historical connection between faith and mental health. Religion and psychology began collaborating for psychotherapeutic purposes in the 1930s in several contexts, including Pastor Norman Vincent Peale and Psychiatrist Smiley Blanton, MD, coming together to form the Blanton-Peale Institute, a collaboration between pastors and psychoanalytically-oriented psychiatrists (American Association of Pastoral Counselors, 2015).

A change occurred on January 4th, 1993, when Dr. Joseph English, president of the American Psychological Association (APA), and Pope John Paul II met in a historic meeting at the Vatican in Rome (Shorto, 1999). Dr. English, the representative of a field that has traditionally treated religion as a form of illness, together with the pope, came to
an agreement that “a full understanding of an individual must take into account the ‘spiritual dimension and capacity for self-transcendence’” (Shorto, 1999). The coming together of these two worlds was significant because the definition of the word *psyche* literally means soul, mind, and spirit. These three are inextricably related, and it is imperative that the two disciplines seek to understand and collaborate with one another for the best outcomes.

With this in mind, the APA is becoming more open to religious and spiritual issues, and Christian leaders are becoming more educated on the biological, psychological, and social causes and treatments of mental disorders (Stanford, 2007). Due to their fundamental differences, it is quite evident why, historically, the church and mental health providers have been previously unable and reluctant to collaborate with each other. However, things began to change during the 20th century, when research became devoted to studying the etiology, symptoms, and treatment of mental illness (Albers, 2012). However, research needs to be done to discover how pastors and secular counselors work with each other, barriers pastors are facing when collaborating with secular counselors, and what can be done to bring the mental health world and faith communities together.

**Current Status of Mental Illness in the Church**

Progress can be seen in certain attitudes across denominations. Many churches partner with the National Alliance on Mental Illness (NAMI) to provide support groups for both sufferers and supporters of those with serious mental illness (National Alliance on Mental Illness, 2015). Ecumenical groups such as Pathways to Promise have
produced awareness and educational materials to promote mental health ministries in churches and encourage collaboration with mental health organizations on a national scale (Anderson et al., 2012). In order to stay relevant, pastors must learn from a variety of disciplines including secular psychiatry and psychology (Leavey, Dura-Vila, & King, 2011). While strides have been made, some say that the church and psychiatry have moved from a posture of antagonism to one of “mutual ignorance” (Anderson et al., 2012), choosing to remain ignorant of one another’s philosophy or training and simply tolerate one another, rather than engaging in illuminating dialogue and forming lasting partnerships. Stanford (2011) states that the church needs to stop viewing mental illness as the result of spiritual warfare or personal failures and establish a stance on the topic considering the biological and spiritual components of sin. Further research needs to be done to explore pastors’ understanding regarding mental illness and how a person's biology can affect their mental health. Ongoing research needs to be done to further understand what pastors are being taught in their formal education on the subject of mental health.

**Mental Illness and Stigma**

One in five Americans lives with a mental health disorder, and it is estimated that two thirds of individuals living with a mental health disorder do not seek treatment (National Alliance on Mental Illness, 2015). This could be due to the fact that mental illness is stigmatized in American society, and the church is no exception. Stigma is a profoundly pejorative way of misnaming people and occurs when one aspect of a person is highlighted in such a way that people consider it to be the only or the most important
aspect of that person’s life (Swinton, 2001). Potential consequences of stigma include experiences of disgrace and shame that can lead to denial and silence. This silence and denial can lead people to be reluctant toward seeking treatment, and may stop them from being able to have an open discussion on mental illness, which is needed in the church (Albers et al., 2012). Seeing a pastor for counseling can often break down walls and avoid the stigma often associated with seeing a secular counselor (McGinnis, 2015). Communities of faith can be instrumental in reducing the stigma of secular counseling, providing opportunities for coalitions that can reach more people, and acting as a gateway to professional mental health treatment (McGinnis, 2015; Vanderwaal, Hernandez, & Sandman, 2012).

Although faith communities have the opportunity to help reduce the stigma that surrounds mental illness, mental illness remains a taboo topic among the church with 66% of pastors reporting that they never or rarely speak about mental illness from the pulpit. Of these churches, 65% of the congregation report wanting a more open discussion from their pastors about this topic (Bornsheuer et al., 2012; Smietana, 2014). Smietana (2014) further speculates that the lack of discussion on this topic may cause those suffering from a mental illness to feel ashamed and therefore not seek the help they may need.

**Pastors as Frontline Mental Health Workers**

According to a study conducted by Bornsheuer, Henriksen, and Irby (2012), 56% of Protestant church members surveyed stated that religion plays an important role in their lives, and 70%-80% of persons in the United States attend church regularly (Polson
& Rogers, 2007; Wood et al., 2011). Therefore, it is not surprising that pastors are more likely than both psychologists and psychiatrists combined to be approached for help by a person who has a mental-health diagnosis (Bledsoe et al., 2013; Bornsheuer et al., 2012; Stanford, 2007; Leavey et al., 2011; Oppenheimer et al., 2014; Vanderwaal et al., 2012). More than half of all pastors have worked with a person having a mental health or substance abuse problem in their churches at least monthly (Vanderwaal et al., 2012). In fact, pastors serve four out of 10 Americans with mental-health problems (Oppenheimer et al., 2004). Furthermore, it is reported that pastors spend approximately 15% of their time in pastoral counseling (Weaver, Flannelly, Garbarino, Figley, & Flannelly, 2003; Wood et al., 2011). Pastoral counseling uses biblical and psychological understanding in order to provide healing for an individual. Pastoral counselors also use insights and principles derived from theology and the behavioral sciences in working on mental health issues with individuals, couples, families, groups, and social systems. In order to become a certified pastoral counselor, one must be a licensed mental health professional and have in-depth religious or theological education (American Association of Pastoral Counselors, 2012). However, due to the lack of oversight in the pastoral counseling field, it is unknown how many church leaders who practice pastoral counseling are certified. According to a study assessing pastoral counseling competence by Giblin and Barz (1993), pastoral counselors are likely to focus on the interpersonal, intrapersonal, and spiritual issues of their congregants and less likely to focus on recognizing and treating mental illness. Pastors are often hesitant to refer congregants to secular counselors. It is worrisome that there is a lack of emphasis on the need to treat the
mental illness itself. Further research could explore how many pastors who engage in pastoral counseling are certified and how many pastors participating in pastoral counseling seek continued education in the mental health field.

With the literature stating that those struggling with mental illness seek out the services of pastors when experiencing crisis such as grief, trauma, depression, changes in family, changes in health, injury to self or a loved one, and death of a loved one (Weaver et al., 2003), the pastor’s role in the congregants’ recovery process is extremely important (Ross & Stanford, 2014). Because of this, pastors are often referred to as frontline responders to those suffering from mental health issues (Bornsheuer et al., 2012; Nichols & Hunt, 2011; Oppenheimer et al., 2004; Polson & Rogers, 2007; Vanderwaal et al., 2012; Wood et al., 2011).

While the literature overwhelmingly supports a paradigm of pastors as frontline mental health workers, there is a disconnect between pastors’ perceptions of themselves in the role and accepting that role (Nichols & Hunt, 2011). Even in the face of overwhelming data that demonstrate that they are often the first point of contact people in distress seek out, pastors largely do not pursue mental health training beyond the minimal coursework in seminary, if they went to seminary at all (Nichols & Hunt, 2011). Further research should be conducted to discover the reasons why pastors are not seeking out training in the mental health field. Research should also be done to see if these trainings are being made available to pastors.

It is critically important to understand what services pastors provide to those with mental disorders, especially as literature suggests the importance of conforming to
evidence-based practices (Wang, Bergland, & Kessler, 2003). Surveys have revealed that many pastors are insufficiently trained in recognizing the presence and severity of mental illnesses as well as in providing pastoral counseling (Leavey et al., 2012; Ross & Stanford, 2014; Wang et al., 2003; Wood et al., 2011). In fact, only 38% of pastors feel equipped to identify a person dealing with mental illness (LifeWay Research, 2014).

Pastoral knowledge in regard to mental health is critical to providing appropriate care to congregants, and having a higher level of training can lead to greater understanding of the mental health problem (Polson & Rogers, 2007).

**Effectiveness of Christian Counseling**

Research on religious coping has shown faith to be a method individuals rely on to gain control in their lives. Connection with a church can offer additional social support, which those who suffer from a mental illness often lack. Many reported feeling less alone and more hopeful after creating a social support through the church (Coursey & Lindgren, 1995; Nooney & Woodrum, 2002; Salsman, Brown, Brechting, & Carlson, 2005). Furthermore, many studies find that attending church and praying regularly are associated with positive mental health outcomes (Coursey & Lindgren, 1995; Ellison 1995; Levin & Chatters, 1998; Levin & Taylor, 1998; Nooney & Woodrum, 2002).

However, one study found people who sought help from pastors stated that the church made them feel like their mental illness was the result of personal sin, disclosed that they felt that the church suggested that they or their loved one did not have a mental illness, stated that the church discouraged them from using psychiatric medication, felt that their mental illness was worse after church involvement, and stated that the interaction with
the church in regard to their mental illness weakened or destroyed their faith (Stanford, 2007). Overall, 30% of mentally ill Christians who sought help from pastors found it to be counterproductive to their recovery (Stanford, 2007). This study shows that while faith can have a positive impact on a person and their mental well-being, pastoral counseling can have a negative impact on recovery due to the lack of education and understanding that pastors have in the mental health field. This research will discuss pastors’ experience when working with a congregant suffering from a mental illness and will examine if pastors feel their intervention has made a positive impact on the life of the congregant.

**Pastoral Counseling**

Pastoral counseling has changed over time in an effort to try to improve its effectiveness. Gary R. Collins (2007), in his book *Christian Counseling*, discusses the differences between traditional and modern forms of Christian counseling. Traditionally, Christian counseling has taken a modernist and scientific approach focusing on the past and long-term strategies. The new Christian counseling approach is postmodern focusing on the present and the future with brief strategic counseling. In traditional Christian counseling, the counselor was thought to be the expert and superior to the congregant in knowledge and training; however, in the new Christian counseling approach, the counselor is the “wounded healer” who may have some training but is not superior to the congregant. Traditional Christian counseling focused on facts and data with the counselor as the guide, minimizing cultural issues and art, with great emphasis on the pastor’s credentials and knowledge. In the new Christian counseling, the
counselor focuses on telling and creating the story of the congregant and the counselor and congregant participate and interact with one another, cultural issues are considered important, and the counselor may try new forms of therapy such as art or music therapy. The similarity between traditional and new Christian counseling is they both use the Bible as their foundation (Collins, 2007). It is unknown how many pastors have changed their practices to fit a changing society or their changing church. An area of study that is not well explored is what types of counseling theories pastors are utilizing when working with their congregants. Pastors who ignore or demonize the biomedical model for mental health treatments run the risk of blocking access to available mental health resources (Sullivan et al., 2013). Although there has been a push to allow mental health and faith communities to work hand in hand, researchers have been finding a need for a more balanced approach and have found that some aspects of religion can undermine emotional well being (Ellison et al., 2013). This research will investigate what pastors need in order to work more collaboratively with secular counselors and how this can benefit the congregant.

There is a lack of research to show the effectiveness of pastoral counseling. Some studies state that there are those who feel they have been harmed due to pastoral counseling; however, the available data are inconclusive. Further studies should be conducted to research the effectiveness of pastoral counseling.

**Education of Ministers**

A study conducted to identify a pastor's ability to recognize mental illness found that approximately 71% of Baptist senior pastors expressed the ability to recognize
mental illness, although they refer less than 10% of the people they counsel to professional psychologists (Stanford & Philpott, 2011). Despite the fact that 95% of pastors believe that counseling congregants is important, only 25% feel that seminary training adequately prepared them to provide such services (Farrell & Goebert, 2008). Overall, pastors do not report high levels of confidence in their own counseling abilities, nor do they believe their prior training adequately prepared them for counseling (Collins, 2007; Leavey et al., 2011; Polson & Rogers, 2007; Ross & Stanford, 2014). Many pastors desire continued education in the field of mental health (Bornsheuer et al., 2012; Polson & Rogers, 2007). However, according to Polson and Rogers (2007), less than half of those interviewed had training in clinical pastoral education.

Donald Capps (2012) describes several reasons why all pastors should be properly trained in mental illness. After stating that the most obvious reason why ministers should be adequately trained is because they will be working with people who are directly affected by mental illness, Capps notes that many persons at risk of mental illness are often in their teens or early 20s. Capps believes that youth pastors often have better insight into the lives of teens than their parents and teachers, and therefore should be able to properly recognize signs of a mental illness. Capps states that some ministry students may be suffering from a mental illness or be susceptible to one, and suggests that there are correlations between a congregation’s church affiliation and the mental diagnosis they receive. Capps (2012) believes that the field of psychology is working toward a mindset of prevention rather than treatment, and hopes that pastors and the church can play a role in helping prevent mental illnesses. The only way to succeed in
this, according to Capps, is to have proper training and education. As a part of the training that Capps believes that all pastors should have, he refers to the modern pastoral care movement, started by Anton T. Boisen in the early 1920s, which strives to have seminary students spend several weeks shadowing in a mental institution in order to gain empathy and a better understanding of those with mental illness. Finally, Capps hopes that through training, ministers can play an important role as advocates for the mentally ill and their family. His hope is that pastors will inspire church members and others to create an environment of openness and acceptance toward those with a mental illness (Capps, 2012).

Despite this call to action by Capps, and the research done by Polson and Rogers (2007), which found that 93.9% of pastors surveyed reported that they needed continuing education to work with those suffering from mental illnesses, training among pastors who counsel those with mental illnesses is marginal at best. In a 2014 study, 70 accredited seminaries were assessed for extensive mental health training for master’s of divinity students (Ross & Stanford, 2014). According to a telephone survey, 88% of seminaries offered courses where mental illness was addressed in some form; however, only 43% offered counseling courses where mental illness was specifically addressed. The authors deduce that these findings emphasize the need for increased mental health awareness and education in seminaries (Ross & Stanford, 2014). The study cited above only surveyed a small portion of schools educating ministers and only looked at one level of education that ministers may have. It may be beneficial to the field to reach out to pastors individually and inquire as to what kind of professional training they were
given through their formal education. In addition to researching why there is a lack of training among higher education institutions in the field of mental health, the field could benefit from research determining how pastors perceive the quality of the training they received while at seminary or Bible College.

**Collaboration between Secular Counselors and Pastors**

Increasing evidence suggests spiritual beliefs can have a positive role in a client's recovery making it crucial that pastors and secular counselors learn to collaborate in order to best help their consumers (Bledsoe et al., 2013; Bornsheuer et al., 2012; Butler & Zamora, 2013; Leavey et al., 2012; Sullivan et al., 2013; Vanderwaal et al., 2012; Wood et al., 2011). In fact, the Joint Commission on Accreditation of Healthcare Organizations requires health care professionals to assess spirituality and provide spiritual care when the client requests (Gomi, Starnino, & Canda, 2013). Literature on the importance of the intersection between spirituality and mental health is plentiful. What has been lacking, however, is a model or a template for collaboration between pastors and mental health professionals (Sullivan et al., 2013). Despite the relative lack of empirical research on the role of spirituality in the lives of mentally ill individuals, personal accounts and qualitative studies have demonstrated the importance of religion and collaboration in recovery from mental illnesses (Coursey & Lindgren, 1995; Gomi et al., 2013; Nooney & Woodrum, 2002; Yangarber-Hicks, 2004).

There are concerns for both religious leaders and secular counselors when partnering with each other. Reasons for the pastors’ refusal to refer out to psychologists vary but include perceived differences in values, being uninformed of available services,
the stigma associated with being seen by a mental health professional, and/or whether the person had the resources and financial ability to afford treatment (Ross & Stanford, 2014; Stanford and Philpott, 2011; Weaver et al, 2003). In a study conducted by Farrell & Goebert (2008), 41% of the responding pastors stated that shared religious beliefs between the client and the secular therapist are “important” and another 15% of responding pastors stated that those shared beliefs are “essential” (Ross & Stanford, 2014). Additional sources found that pastors are more comfortable referring to secular counselors if they know that the counselor has the same religious belief as they do and the congregant (Polson & Rogers, 2007; Vanderwaal et al., 2012). While pastors value religious belief in psychologists, psychologists value more education in pastors to whom they refer (Ross & Stanford, 2014). It was found that psychologists are more likely to refer religious clients to pastors with a doctoral degree to answer religious questions (Ross & Stanford, 2014).

Despite studies stating that collaboration is necessary, it remains difficult. Three reasons why collaboration between pastors and secular counselors remain challenging have been identified. The first reason being a lack of trust between the pastor and the secular counselor that can occur. Secondly, stigma often undervalues the contributions of pastors and mental health clinicians. Thirdly, there is a general lack of knowledge regarding ways pastors and mental health professionals can successfully collaborate (Farrell & Goebert, 2008; Sullivan et al., 2013). In fact, there is almost no literature that looks at why the integration between spirituality and health has not been explored and
why it is so difficult to achieve (Sullivan et al., 2013), underscoring the need for this study to explore these barriers.
Chapter 3

METHODOLOGY

This chapter discusses the research methodology utilized to complete the master’s project. The research study used the qualitative approach to assess the experiences and perceptions of pastors ministering to congregants with mental illnesses. The research methods used to recruit research subjects and collect data are summarized below.

Study Objectives

This exploratory study was designed to gather qualitative information from pastors who serve as frontline mental health workers to their congregants experiencing a mental health crisis. The objective was to evaluate how pastors are responding to such congregants and their perceptions of those with mental illness. This study aims to find what could better prepare pastors to be frontline mental health workers, and how social workers can better understand the resource and collaboration needs of pastors. This chapter includes a discussion of the methods the researchers utilized for the study and is organized in the following sections: (a) Study Design, (b) Sampling Procedures, (c) Data Collection Procedures, (d) Research Instruments, (e) Data Analysis, and (f) Protection of Human Subjects.

Study Design

This study utilized in-depth qualitative interviews and a brief demographic survey (Appendix A) conducted in person. The goal of this study was to help understand the perceptions, experiences, and service needs of pastors working with
congregants with mental illness. Participants were asked to sit down for a 30-45 minute face-to-face interview with one of the investigators and discuss their background with mental illness. They were asked to complete a brief demographic survey that took approximately five minutes.

**Sampling Procedures**

The study population for this project included Christian pastors with a direct service practice in the Northern California region. The authors of this study emailed and called pastors, using a prewritten script (Appendix B and Appendix C), whom the investigators had identified as having face-to-face interaction with congregants. The researchers identified them as having face-to-face contact with congregants by their title. For example, the pulpit pastor, youth pastor, or associate pastors are all job titles in which the pastor interacts face to face with congregants. Investigators have knowledge of this by their own experience within the Christian church and their own experience interacting with pastors. In the email and telephone conversations with pastors during recruitment, the authors of this study stated that to qualify for participation in the study pastors must have interaction with their congregants. The sample type of this research study is convenience. Convenience sampling is a nonprobability sampling method, and it relies on data collection from population members who are conveniently available to participate in a study.

**Data-Collection Procedures**

The data for this study were collected through face-to-face interviews at a location convenient to the pastor, such as their office. The investigators ensured that the
confidentiality of the participants were protected by interviewing each other’s contacts. The investigators did not interview any pastor that they had a preexisting relationship with. Demographic information was collected at the time of the face-to-face interview with a brief survey. The investigators informed the pastors that their participation was voluntary and confidential. The investigators provided the participants with implied consent forms (Appendix D) and allowed them to keep a copy of the implied consent.

The interviews took approximately 30 to 45 minutes to complete and the demographic survey took approximately 5 minutes to complete. The interviews were recorded on a digital recording device only available to the investigators. During the interviews the investigators asked the main research questions and probed when necessary. The investigators then transcribed the interviews onto a Microsoft Word document on a password-protected computer. The audio recordings of the interviews were then deleted from the digital recording device. After all the interviews were transcribed, the researchers numbered them one through 11. The researchers analyzed the data using Microsoft Word track changes. Demographic surveys were given to the pastors to fill out. The pastors were asked not to put their name on the survey. They then were placed into a sealed envelope and immediately entered into a Microsoft Excel document on a password-protected computer. Once the demographic surveys were entered into Microsoft Excel, paper copies were shredded and discarded.

**Research Instruments**

The research instruments used in this study include a semi-structured interview guide to help facilitate the face-to-face interviews and a self-administered questionnaire.
consisting of five questions. The hard copy questionnaire was completed by the participant with pen or pencil. The authors of this study, under the advisement of their thesis advisor, Dr. Jennifer Price Wolf, developed the semi-structured interview guide and demographic survey. The semi-structured interview guide (Appendix E) consisted of five questions regarding the pastor's history with and perceptions of mental illness. The demographic survey consisted of five questions asking about the pastor’s education, denomination, job title, and trainings related to mental health. The questions were designed based on the literature review and on the investigator's knowledge of the Christian church.

**Data Analysis**

The qualitative interviews were 30 to 45 minutes in length and were recorded on the researcher's password protected mobile telephones. The interviews were conducted in a private location convenient to the participant. In eight out of 11 cases the interviews were conducted in the pastor's private office. In one case the pastor requested to be interviewed in the church library, another case the pastor requested to be interviewed in the church auditorium due to not having a private office, and the final pastor was interviewed over Skype at his request. The investigators transcribed the interviews into a Microsoft Word account on password-protected computers. Once the interviews were transcribed, the investigators deleted the interviews off of their password protected mobile telephones. The investigators then coded the interviews using Microsoft Word track changes. The transcribed interviews were coded by keywords to allow the authors of this study to analyze their data. Once the interviews were transcribed, they were
numbered one through 11 in order to secure the pastor’s confidentiality. The investigators then drew conclusions based up on the participants’ answers to the interview questions. Demographic surveys were entered into Microsoft Excel for comparisons. When analyzing the data, the demographic information was not linked to the qualitative surveys. The authors of this study did not use demographic data to identify the pastors throughout the body of the paper. The original demographic surveys were shredded and discarded.

**Protection of Human Subjects**

The researchers drafted the application for the Protection of Human Subjects in September 2015, under the advisement of project advisor Dr. Jennifer Price Wolf. The application was reviewed and approved by the advisor and was submitted to California State University, Sacramento, Division of Social Work Committee for the Protection of Human Subjects on October 1, 2015 for review and approval. Two weeks later, the researcher was notified by email on October 14, 2015 that the application for Protection of Human Subjects was approved pending modifications. After consulting with Dr. Wolf, the investigators made changes to meet the expectations of the reviewers and returned the application to the committee chair for approval. On October 16, 2015, the investigators received an email stating the Human Subjects application for this study was approved as Exempt. The human subjects protocol number for this project is 15-16-016.
Physical or Psychological Risk

Physical risk was not applicable to this study because the participants were only asked to fill out a paper survey and sit down for a 30-45 minute face-to-face interview. The psychological risk in this research involved interviewees possibly becoming stressed or embarrassed if they were not confident in their ability to counsel their congregants. They may have also become anxious if they thought about past consumers or may possibly have went through retraumatization. This risk was minimized by the investigators maintaining professionalism and stressing confidentiality throughout the interview. Interviewers had a list of professional resources on hand if a referral needed to be made. The interviewees paused or terminated the interview if the interviewee appeared overly distressed. The authors of this study did not have to pause or terminate interviews due to the interviewee appearing overly distressed.

Privacy Risk

The privacy risk was listed as minimal and was minimized by protecting possible ramifications to employability. Investigators accomplished this by keeping demographic data separate from interview data and not linking the two. For example, the transcribed interviews were entered into Microsoft Word and each pastor was assigned a number, one through 11, in random order and the demographic surveys were entered to Microsoft Excel without names attached. The demographic information and the transcribed interviews were not entered in the same order so as to keep identities separate. The survey did not target identifiable variables such as name, home address, social security number, and driver’s license. After the data were collected, they remained locked at the
researcher’s residence. Data were only available to the researchers and their thesis advisor. The questionnaires were destroyed after the data were entered into Microsoft Excel. The interviewers maintained professionalism and stressed confidentiality throughout the interview. Investigators had a list of professional resources on hand if a referral needed to be made. Preexisting relationships with participants did exist in this study; however, the authors of this study did not interview the person they had a preexisting relationship with. If there was a preexisting relationship with a participant, the other author conducted that interview. No human subjects violations or incidents occurred during this study.
Chapter 4
RESULTS

This chapter examines and presents the outcomes acquired from 11 qualitative interviews conducted with pastors who have direct contact with congregants who may be suffering from a mental illness as well as the 11 demographic surveys those pastors completed. To recap, this study examines the experiences and perceptions of pastors in ministering to congregants with mental illnesses.

Demographic Information

For the purposes of this study, basic demographic information was collected through a five-question demographic survey. Out of the 11 pastors interviewed, all 11 (100%) were Caucasian, 10 out of 11 (90%) identified as male and one out of 11 identified as female. Six out of 11 (54%) of pastors interviewed had a master’s degree or higher, three out of 11 pastors (27%) had completed a bachelor's degree, and two out of 11 (18%) reported having less than a college level education. Seven out of 11 (63%) pastors who hold bachelor’s or master’s degree had a degree in the field of ministry. Four out of 11 pastors (36%) of pastors interviewed had a master's degree in divinity, one pastor (.09%) reported having a master’s in evangelism discipleship, one pastor (.09%) stated he had a master’s in theology, and one pastor (.09%) reported having a bachelor’s in youth and family ministry. Of the two out of 11 (18%) of pastors interviewed who reported not having a degree in ministry, one reported having a bachelor’s in animal science, and one a bachelor’s in business administration. Two out
of 11 (.18%) pastors reported not having a college degree. One of the pastors without a college degree reported attending biblical training through his/her denomination.

Pastors were also asked to disclose the amount of training they had in the field of mental health. One out of 11 (.09%) reported having no training in the field of mental health. Six out of the 11 pastors (54%) reported their only training to be the courses taken during their formal education. One pastor (.09%) reported having several forms of training including: pastoral care & counseling coursework training, mental health first aid training, critical incident stress management (CISM) training, Stephen Ministry and Stephen Leader training, and clinical pastoral education. One pastor out of 11 (.09%) stated his training as the Association of Christian Counselors Intensive, a weeklong seminar he attends once a year in Nashville, Tennessee. One pastor (.09%) who reported not having a college degree in ministry reported receiving one training on mental health during ordination. One pastor (.09%) who reported not having a college degree in ministry stated his training as four units of biblical counseling at Western Seminary and Nouthetic counseling training.

Finally, pastors were asked about their years of experience in ministry. The amount of years in ministry ranged from six years in the field of ministry to 33 years in the field of ministry. The median years of experience the pastors had in ministry was 13.72 years, and the standard deviation of experience was calculated to be 7.96 years.

**Qualitative Interviews**

Face-to-face qualitative interviews were conducted with 11 pastors in the Northern California area in order to better understand how pastors view the services they provide
to congregants with mental health disorders, the experiences pastors have of ministering to congregants with mental health disorders, pastor’s perceptions of mental illness, and what the perceived training and/or resource needs of pastors working with congregants with mental illness are. Pastors were asked a series of five main research questions over a 45 minute in-person interview aimed at answering these questions. Several themes were found throughout all the interviews such as the roles they hope to play in a congregation's life, what they need to feel more confident in ministering to those with a mental illness, how they feel about referring congregants to non-Christian counselors, and the type of work that pastors do. There were varying responses found throughout the interviews such as a pastor's comfort level referring a client to a non-Christian counselor, pastors who believe mental illness is a spiritual versus neurological issue, and the role that a pastor may play in the life of someone with a mental illness. These similarities and discrepancies helped the researchers better understand how pastors are working with congregants with a mental illness. Additionally, every pastor interviewed revealed that they have come into contact with a congregant who was coping with a mental illness. Pastors identified bipolar disorder, addiction, autism, schizophrenia, and depression as some of the mental illnesses they have encountered during their careers.

**Pastoral Care**

All 11 pastors described pastoral care as one of their main ministry roles. However, the concept of pastoral care presented differently in each pastor interviewed. For example pastor number two stated, “I often describe pastoral counseling as triage,” pastor number four described pastoral care as, offering “appropriate support to them
when I can,” and “my role is a theological one, a pastoral one of offering God’s grace and assurance. Connecting them with God as a healer is my job.” Pastor number three stated, “The main thing was don’t try to be Jesus we can’t, we aren’t equipped that way.”

Pastoral care manifests itself differently in each pastor's interpretation of the term. However, pastors, defined pastoral care as providing support, comfort, a listening ear, educating congregants about the Bible, and offering resources to the congregant.

Roles Pastors Wish to Play When Ministering to Those with Mental Illness

Pastors reported wishing to play several roles when ministering to congregants, including the roles of supporting the congregant, providing a community to the congregant, acting as a first responder, and breaking the stigma mental illness may carry.

Support

As to the role they see themselves playing in an individual's life who is struggling with a mental illness, 10 of the 11 pastors interviewed stated it was not their job to be the counselor or the therapist in a congregant’s life. Throughout the interviews it became clear that the pastors viewed themselves as a support person to congregants struggling with mental health and capable of offering them that support from a spiritual standpoint. For example, pastor number four stated, “My job as a pastor to a parishioner with mental illness is one I call accompaniment, accompanying them through the process” and pastor number nine stated, “I’m going to triage … I’m going to support them, pray for them, but I’m going to refer them to someone who is professionally trained.” Pastor number six stated, “My main job is being nonjudgmental. My job is being a listening ear most of the time. My job is not to judge, but to help them love the
Lord their God with all their heart, soul, mind, and strength and love their neighbor as themselves.” It was clear throughout 10 of the interviews that pastors did not desire to be a therapist to their congregants. Of the 11 pastors, 10 desired to be a part of a congregant’s support system while they learn to cope with and manage their mental illness.

**Community**

Three of the 11 pastors focused on the need for community and viewed their church as one that could provide that sense of community. For example, pastor number 10 stated, “I see my role as surrounding them with a community that accepts and understands them in their brokenness” and “The role of the church is a lot about supporting and offering a community and a safe place in tandem with the other avenues that the individuals are seeking out to find healing.” Pastor number three stated, “[my job is to] remind them that spiritually they are loved and they are not alone and they have community and try to be that voice.” Pastor number seven stated he believes people who do not function well in other social situations gravitate toward the church for community because “they tend to be more gracious, forgiving, and accepting.” Having a circle of support is important when coping with and recovering from a mental illness and pastors desire to fill that role as a part of their pastoral care duties.

**First Responder**

An additional role 10 out of the 11 pastors felt they played in the lives of congregants with mental illnesses was one of triage or first responder. Pastor number nine described his counseling duties as, “meet with them once, twice, maybe three times
and after that, they need to seek someone who is better trained than I to address their issues,” and pastor number one stated, “I am very much kind of a first responder and then someone who can kind of be the conduit.” Pastors number 11, two, and seven stated they have a contract they have written up themselves or is on their church website that states the counseling services they can provide. This contract includes things such as defining their limitations as a counselor, their mandated reporting requirements, and the process of referring a congregant to a professional counselor. For example, pastor number one stated,

I know what my limits are and I’m pretty clear about that with myself and with others, so when they come in and see me I say I’m glad to meet with you but if it seems like something more than I can provide, I’ll be glad to make those referrals and help create an opportunity for you.

These pastors expressed that it was important for them to recognize their limitations and to be honest with the congregants they work with.

**Breaking Stigma**

One of the roles three of the pastors stated they desire to play in the lives of their congregants is the desire to decrease the stigma an individual may have in seeking mental health services. For example, pastor number one stated, “If I can be an entry point for mental health care, I’m glad to be that conduit.” Pastor number 11 stated, “I’ll talk to them about psychiatry and what that entails and how there’s no shame in it.”
Lenses through Which Pastors Work

Throughout the interviews the researchers were able to discover 10 out of the 11 pastors interviewed viewed mental health as a holistic problem. Many stated they believed there were neurological, biological, environmental, and spiritual components that made up a mental illness. For example, pastor number one stated,

It’s biological. It’s a health issue. It is also driven by factors of experience and trauma and chemical imbalances of the brain. It can cover all of those things but it can also just be broad mental health. Mental illness can be brought on by daily life experiences. So it depends on the person and the circumstance.

Additionally, when asked what his concept of mental illness is, pastor number six stated, “I believe in God, but sometimes biology and chemistry, they happen. I think it’s genetic, it’s hereditary.” Furthermore, pastor number eight stated, “I do see there are a lot of different chemical levels, maybe some deficiencies, I think some of it could be social or some type of environmental experiences. I think some of it could be hereditary.” Pastor number 10 stated, “I think that there must be some sort of spiritual component to it because I believe in a holistic approach to life. Our emotions, our physicality, and our spiritual nature are all entwined.”

Through his interview, pastor number 11 revealed he works with congregants with a mental illness through a medical model stating, mental illness is:

Just like any other illness…you wouldn’t be ashamed to go to a doctor if your leg was broken, but if you wait for your leg to heal on its own you’ll be a mess. So I try to relieve some of that social anxiety about going to see a psychiatrist.
Pastor number nine aligned with pastor number 11, stating he viewed mental illness as “it’s something that needs to be treated and can be treated by healthcare professionals, just like a medical illness.”

The authors of this study did find an aberrant case during their interviews. Pastor number five was the only pastor interviewed who expressed feeling mental illness is a purely spiritual issue. Pastor number five stated he only treats mental illness through a spiritual lens stating,

We primarily look at the basic issue as being based in the spirit. In counseling it is common to focus on behavior modification. We see the root as being spiritual.

When we get that right, many of the behaviors fall into line.

Therefore, pastor number five is committed to finding a way to treat mental illness from a biblical standpoint within their church community. Pastor number five spoke about demon possession and how that can present to a secular counselor as a mental health disorder. For example, he stated he worked with a mother who was hearing a man's voice. To respond, the woman and the leadership team “submitted to deep prayer” as a form of healing. In another case pastor number five spoke about, a woman “would wake up in the middle of the night and it felt that something was sitting on top of her chest, almost demonic in nature. She had really bad dreams and couldn’t get him out of her mind.” Pastor number five stated that at an elder’s meeting they had a time of prayer and confession for her. During this time they were able to discover the woman had a history of sexual abuse. Instead of referring this woman to professional counseling they “tried to help her to see that Christ was there” and that “God is ready to help her to heal
because God says that He is the healer of the broken-hearted.” Pastor number five then went on to say, “we began to pray on that. It was a long prayer session and very emotionally draining. She had deliverance and the dreams and some of the other behaviors stopped.” Pastor number five and his church are committed to healing mental illness for a spiritual point of view and look at how the Bible might shed light on this individual’s situation.

Pastors work through many lenses when working with a congregant with a mental illness. Although the majority of pastors interviewed for this study stated they felt a congregant with a mental illness needed a holistic approach to healing, two pastors revealed they worked more from a medical model and one pastor stated he focused solely on the spiritual aspect of healing for a mental illness.

**Referring Congregants to Professional Counselors**

Of the 11 pastors interviewed, 10 rely heavily on the idea of referring congregants to professional counselors when they feel the congregant’s needs are beyond their personal training. Pastor number six stated, “As far as serious mental illness, I would refer. I have a very limited scope and very limited power that I can exercise in that situation.” Pastor number three stated, “I believe in counseling and talk therapy from qualified people.” Pastor number four stated, “I could give resources and a list of referrals.” Pastor number 10 stated, “I did some counseling for him, but I always considered that secondary to meeting with psychiatrists and doctors. I wouldn’t classify what I was doing as counseling.” Pastor number 11 stated, “probably the very best thing that I can offer people is to refer them out.”
However, pastor number five, who has an education in a field unrelated to ministry, felt more confident to handle the mental health needs of his congregants without the education or training that other pastors felt they were missing. For example, pastor number five stated their church is training congregants to take on the role of being a “biblical counselor.” This church is finding people within their congregation who want to go through a counseling course taught by the pastor to better understand how to counsel someone with a mental illness. This pastor, and his church, believes that the world of psychiatry and religion are at odds with each other. Therefore, they are committed to finding a way to treat mental illness from a biblical standpoint within their church community.

Referring to Christian or Non-Christian Counselors

Another finding the authors of this study were able to determine is, contrary to the literature, nine out of the 11 pastors interviewed stated they would feel comfortable, and have referred congregants to non-Christian therapists. Pastor number one stated, “some individuals may need a more clinical approach and some may need a more faith-based approach.” Pastor number nine stated, “I would refer to the best person to do the job. I don’t think there is any corner on the market just because you’re a Christian or not a Christian, it’s are you the best person to treat this person?” Pastor number six stated, “I’m actually probably more comfortable referring to a non-Christian therapist over a Christian therapist. Their religious beliefs are not necessarily the thing that makes me more or less comfortable.” Pastor number six went on to discuss the negative experiences he has had both personally and professionally with professional counselors
who identify as Christian. For example, this pastor stated he and his wife attended marriage counseling due to some hardships they were having as a couple. He stated the counselor they went to was a licensed marriage and family therapist and used religion through his therapy with clients. The pastor went on to share how the counselor only spoke about healing through the Bible during their sessions and gave no practical tools on how he and his wife could overcome their struggles. Due to this and other professional experiences pastor number six feels more comfortable referring clients to professional counselors who do not identify as Christian for the purposes of therapy.

However there were two pastors who felt strongly that a Christian struggling with mental illness needs to be seen by a Christian counselor. For example, pastor number three stated through his education he was always taught to refer congregants to professional counselors; however, he stated, “I can’t, in good faith, refer someone to someone I just don’t know what you mindset is if you’re not a believer and don’t have any access to the Holy Spirit or the power of God or have any belief in that.” Pastor number three felt strongly that in order for a person of faith to be able to cope with and heal from a mental illness, they need a therapist who holds the same value system as they do. Pastor number three also emphasized that just saying you are a Christian counselor does not qualify you to counsel someone. Pastor number three stated, “I believe in talk therapy from qualified people.” Pastor number five, another pastor who felt strongly about only referring to Christian counselors stated, they, as a church and leadership team, use prayer as a form of healing citing examples of a time a man was believed to be delivered from Bipolar Disorder after hours of being prayed over by their
eldership, “The pastor prayed over him. He said that it was like he had a black cloud over him and suddenly it just evaporated.” Pastor number five believed strongly that the psychological world and the religious world are at odds with each other and believed in healing a person through a biblical lens. Pastor number five expressed several times throughout his interview that he does not believe the mental health world and the religious world can work hand in hand. Pastor number five believes the two worlds are at odds with each other. Therefore, to refer a congregant to a professional counselor who is not faith-based would do more harm than good to that individual. Pastor number five expressed the value he places on referring congregants to a qualified professional Christian counselor, while pastor number three expressed that he believes he and his church can heal an individual through the power of prayer and relying on the Holy Spirit.

**Collaboration with Secular Counselors**

The interviews revealed only 4 out of the 11 pastors have collaborated with professional counselors. When asked if the pastors felt the collaboration between the mental health provider and the pastor was beneficial for the congregants, pastors number two, four, eight, and 11 stated they saw positive results through collaboration. For example, pastor number two stated, “I felt like people felt genuinely cared for by us because we went the extra mile to connect them to someone who could care for them on a deeper level.” Although many pastors have not had the opportunity to collaborate with professional counselors, pastor number two expressed his desire for ongoing collaboration between the religious field and the mental health field stating “it would be
great if the mental health world would also recognize the value and importance of religion and see the need to partner more intentionally with this community.’’ However, during one interview pastor number five viewed collaboration as impossible stating,

Biblical and secular counseling collide. They operate from two different vantage points. In a secular setting, people are going to look at behavior modification such as Freud or Jung. They are going to go to the DSM. They’re going to go to a person and say that the person exhibits symptoms, which means that they are suffering from this illness. Biblical counseling does not use the DSM. Because of that there would probably be a huge collision. The DSM people would look at the Bible and question why it is being used. There’s some incompatibility there. Whether there’s room at the table for both, I’m not sure.

Throughout the interviews, the researchers found many pastors who would be willing to collaborate with secular counselors; however, they have not been given the opportunity to collaborate. One pastor interviewed stated he does not believe collaboration is possible.

**Barriers to Collaboration**

When asked what barriers counselors have faced in attempting to collaborate with a professional counselor, pastor number nine reported, “I have never seen any barriers personally in collaborating with secular counselors or secular doctors. God uses all of God’s children for lots of different things in lots of different ways.” However, several pastors did see barriers in collaborating; for example, pastor number five stated, “There are some churches that have formed a middle ground, but when it comes to
biblical counseling there would be some incompatibility with the more secular approach. Philosophically speaking, it might be difficult to bring the two together.” Other pastors cited confidentiality and privacy laws as barriers to collaboration. However, overall in the sample of pastors that were interviewed there were few to no barriers identified. Pastor number five identified a barrier he might face if he were to collaborate with a secular counselor; however, was unable to cite specific examples of collaboration.

Training Needs of Pastors

One of the questions the researchers hoped to answer through these interviews was the educational and trainings needs of pastors. Pastors who attended seminary or Bible College reported the training on mental health they received was minimal at best and did not offer the full insight needed to properly care for the population they currently interact with. For example, pastor number nine stated, “Seminaries don’t prepare you for that. I would have had to take special courses for that. They don’t really offer seminars or courses for that kind of thing as well.” Pastor number two expressed he feels there is a certain amount of “ignorance” among pastors, stating,

I feel like I had just a razor, a very thin, education on it. That’s where it is important. I think a good use of seminary time, with regards to issues like this, is recognizing we’re not going to give you a comprehensive knowledge.

Pastors who had some form of education in ministry stated sentiments such as what pastor number two said, “my first affirmation is I’m not an expert on it so I probably know just enough to get in trouble” and pastor number 10 who stated, “I have enough of
an education in this area to know that I’m not equipped and to know that if I try to swim in this pool that I’m going to do more harm than good to that individual.”

When asked what would make them feel more confident ministering to those with mental illness, 10 out of 11 pastors stated more training would help them feel more confident. Pastor number six stated, “I’m not uncomfortable working with the mentally ill, but I would like to be more educated.” Pastor number five stated, “More training in biblical counseling would certainly be helpful.” Pastor number three expressed frustration over the lack of knowledge he has stating, “I feel frustrated sometimes because I have to look up things. I feel like I could use seminars or education tools on the topic.” Pastor number two stated he felt like he would be more confident in pastoring to the mentally ill if he had a support group made up of pastors he could go to for advice and to share experiences. Pastor number two also stated he would feel more confident if he were connected to the mental health community even suggesting the mental health community host a yearly conference for pastors. Pastor number two elaborated, stating, Spirituality is a key component to helping someone cope with great trauma in their life and move through to a healthy place. I think the same would be true for the mental health community and engaging churches, parishes, and their spiritual leaders and saying we recognize and affirm you.

Every pastor interviewed stated they needed something in order to have more confidence in the field of mental health from some form of continuing education to a connection with the mental health world.
Through 11 interviews the researchers were able to determine how pastors view the services they provide to congregants with mental health disorders, the experiences pastors have of ministering to congregants with mental health disorders, pastor’s perceptions of mental illness, their ability to and willingness to collaborate with professional counselors, and what the perceived training and/or resource needs of pastors working with congregants with mental illness are. Overall it was found that all the pastors interviewed have come into contact with mental illness over the course of their careers. It was found that a majority of pastors desire to play a supportive role in the lives of congregants struggling with mental illness and rely heavily on referring a congregant to a professional counselor. Only two pastors stated they would only refer to a professional Christian counselor and only one pastor stated he and his church believe in the power of prayer as the sole form of healing in someone’s life. Many pastors revealed they desire more collaboration between the mental health and the religious world while one pastor stated he believes this to be impossible. Furthermore, every pastor interviewed stated they need more training and resources in order to better help those coping with mental illness.
Chapter 5

CONCLUSION AND FINDINGS

Face-to-face qualitative interviews were conducted with 11 pastors in the Northern California area. The objective was to better understand how pastors view the services they provide to congregants with mental health disorders, the experiences pastors have of ministering to congregants with mental health disorders, pastors’ perceptions of mental illness, and identifying the perceived training and/or resource needs of pastors working with congregants with mental illness. After analyzing the data, the authors compared their findings to the existing literature in order to better understand what research needs to be conducted. Some similarities were found between the literature and the interviews such as (a) the pastor's desire to play a supportive role rather than a therapeutic role in a congregant's life, (b) pastors viewing themselves as frontline mental health workers, (c) pastors viewing themselves as a conduit to professional mental health services, and (d) the concern about inadequacy of education they receive in seminary. Additionally, there were discrepancies between the literature and the research. For example; research showed pastors spend a large amount of their time counseling those with mental illness; however, the interviews revealed this to not be true for the pastors in this sample. Pastors interviewed for this study felt comfortable referring congregants to secular counselors for professional mental health help; however, literature stated overall that pastors would only refer congregants to a counselor who shared their religious views. These similarities and discrepancies helped the authors
better understand the strengths and limitations of this research, the implication for policy and practice this research may have, and the need for future research on this topic.

**Pastors as Frontline Mental Health Workers**

Through qualitative interviews the authors of this study found pastors did not view themselves as counselors or therapists. Instead, the authors found 10 out of the 11 pastors saw themselves as “first responders” or “triage” workers in working with a congregant with a mental illness. Of the 11 pastors, 10, acknowledged they are not equipped to serve as a congregation's main therapist but expressed wanting to be a part of a congregation's support system and provide them a sense of community. The same pastors who described themselves as first responders stated they wanted to continue to be a part of the congregation's support system while the congregant worked with a professional counselor to learn how to heal from and/or cope with their mental illness.

This finding was not surprising given the fact that literature found that pastors are first responders to those with a mental illness (Bledsoe et al., 2013; Bornsheuer, Henriksen, & Irby 2012; Leavey, Dura-Vila, & King 2011; Oppenheimer et al., 2004; Stanford, 2007; VanderWaal et al., 2012). In fact, pastors serve 4 out of 10 Americans with mental health problems (Oppenheimer et al., 2004). However, what was surprising was that many pastors interviewed acknowledged knowing they were frontline mental health workers, whereas literature revealed there is a disconnect between pastors’ perceptions of themselves in the role and accepting that role (Nichols & Hunt, 2011). There is a need for future research to address how pastors respond as frontline mental
health workers. Future research could also be conducted to reveal how pastors could be better educated as first responders.

**Breaking Stigma**

Literature revealed churches can be instrumental in reducing the stigma of secular counseling, in effect acting as a gateway to professional mental health treatment (McGinnis, 2015; Vanderwaal et al., 2012). However, literature also revealed 66% of pastors reported that they never or rarely speak about mental illness from the pulpit (Bornsheuer et al., 2012; Smietana, 2014). This finding in literature was mirrored in the authors’ interviews. The authors found 3 out of 11 pastors interviewed wished to take on a role in which they would help reduce the shame and stigma that can come from seeking professional mental health services. The idea of stigma around mental health plagues society as a whole but seems to be even stronger within the church community. The importance of breaking this stigma is shown through the role these pastors hope to play in the lives of congregants with mental illnesses.

Future research could be done to determine the reasons why 65% of the congregation reported wanting pastors to discuss the topic of mental illness openly in the church (Bornsheuer et al., 2012, “Mental Illness Remains Taboo”, n.d.; Smietana, 2014), and why 66% of pastors never or rarely speak about this topic from the pulpit. While it could be hypothesized that there is a correlation between the lack of required coursework for pastors in seminary for mental illness, a more thorough review of syllabi at religious institutions could provide a broader understanding of the apparent disconnect.
Equipping Pastors

Literature showed seminary courses on mental illness are rare (Capps, 2012), and many pastors are inadequately trained in recognizing the presence and severity of mental illnesses as well as in providing pastoral counseling (Leavey, Dura-Vila, & King 2011; Stanford & Ross, 2015; Wang et al, 2003; Wood et al., 2011). Not surprisingly, only 38% of pastors feel equipped to identify a person dealing with mental illness (LifeWay Research, 2014). Pastoral knowledge in the field of mental health is critical to providing appropriate care to congregants (Polson & Rogers, 2007). This literature aligns with the findings the researchers discovered during the interviews. Seven out of 11 (63%) pastors interviewed received a bachelor’s or master’s degree in the field of ministry. Out of the seven pastors who hold a degree in ministry all seven stated they do not feel their education prepared them to properly work with a congregant struggling with mental health.

Due to literature showing pastors are often first responders to those with a mental illness, it is vital that pastors have the training needed to know how to respond to congregants with a mental illness. Additionally, literature found, overall, pastors do not report high levels of confidence in their own counseling abilities, nor do they believe their prior training adequately prepared them for counseling. This was clearly seen through the interviews the researchers conducted, as 10 out of 11 counselors stated they would have to refer a congregant to a professional counselor as they do not have the education needed in mental health. The 11th pastor stated he could benefit from more
training in the area of mental health but did not say he would refer a congregant to another professional.

The consistency of this finding throughout the literature and the interviews begs for future research to be done addressing the disconnect between how pastors are being educated in seminary and the population they work with once they graduate. The seven pastors that received a degree in ministry reported taking minimal counseling courses during the course of their education, and the quality of these courses did not prepare them to work with someone struggling with a mental illness. Due to this, the authors have come to the conclusion that there seems to be a resistance among academic institutions to accept the idea that pastors working within a church are working with individuals who could benefit from mental health services, and therefore are not properly preparing pastors for the work they will be doing. Research could be done to determine if the lack of preparation impacts the high burnout rate of pastors. For example, 71% stated they were burned out, and they battle depression beyond fatigue on a weekly and even a daily basis (Fadling, 2009). Additionally, 57% reported they would leave ministry if the opportunity presented itself (Fadling, 2009).

**Mental Illness as a Result of Sin**

Researchers found an aberrant case in the literature where people who sought help from pastors stated the church made them feel like their mental illness was the result of personal sin (Stanford, 2007). This was mirrored in the interview process as well. Pastor number five stated “We see the root as being spiritual. When we get that right, many of the behaviors fall into line.” Pastor number five went on to discuss how
his church uses the power of prayer to heal people from their mental illness. Other pastors discussed how viewing mental illness as a result of personal sin or a result of demon possession can, in their opinions, harm the congregant when struggling with a mental illness. This finding was surprising to the researchers, as they believed more pastors would view the issue of mental health through a spiritual lens; however, many pastors were able to see mental illness as needing a holistic or medical approach to healing. Future research could be done on a larger scale to determine the lens pastors primarily use when working with a congregant with a mental illness or if the one pastor interviewed by researchers has a lens rare in the religious world.

**Lack of Collaboration between Pastors and Mental Health Workers**

Literature suggests that until collaboration between pastors and secular counselors occurs, pastors should seek out continued education opportunities on mental health (Bornsheuer et al., 2012; Collins, 2007; Polson & Rogers, 2007). Additionally, until pastors are trained more thoroughly on the topic of mental health, it would be beneficial for churches to have a referral list for local therapists or additional resources in order to make timely referrals when a client is demonstrating symptoms beyond their training (Bornsheuer et al., 2012; Collins, 2007). The authors found, through their interviews, only one pastor who stated he had a list of resources on hand to give to a congregant who came to him for help. The 10 other pastors stated they would have to look up resources in order to help the congregant. Literatures showed pastors who are familiar with the mental health resources in their community are more likely to access them (Lau & Steele, 1990; Polson & Rogers, 2007). Future research needs to be done to
determine why more pastors do not keep a list of referrals on hand in order to more effectively help their clients. Additionally, it may be beneficial for faith communities if mental health organizations kept an up to date list of resources readily available for pastors in their local communities.

**Theory**

This study utilized a systems theoretical framework and a Christian theological framework. Our findings supported systems theory by revealing the organic and communal way in which an individual recovers from mental illness, and the important role collaboration plays in their healing. A Christian theological framework supported our findings by helping to explain the role of the Bible in framing the problem of mental illness and how pastors approach congregants in respect to counseling.

Christian pastors share a biblical worldview that informs their counseling rather than a theoretical framework (Ogelsby, 1979). The two do not necessarily need to be at cross purposes; however a fuller understanding of psychology and the DSM would assist pastors helping their congregants cope and recover from a mental illness by eliminating misconceptions and finding common ground.

In systems theory this type of collaboration is referred to as an “open system.” While pastors largely acknowledge the need for medical professionals’ expertise as well as the benefit of medication, the church system still remains too ‘closed’. This was evidenced by the lack of collaboration reported by the pastors interviewed as well as their lack of knowledge of community supports and resources.
While historical and professional views previously led society to embrace a psychoanalytic and psychodynamic view of people, a view that prevailed for more than a half century, systems theory can be credited with bringing the environment back into the concept of person-in-environment (Robbins, et al. 2011). If a person with a severe mental illness spends a great deal of time in the church environment, this environment must be viewed holistically by the individual’s pastor as just one part of the person’s life. The individual’s family, friends, workplace, and other people in their life are integral to the person coping and recovering from their illness.

**Referring Congregants to Non-Christian Counselors**

In the study interviews, it was found only 2 out of the 11 pastors felt it was important for the secular counselor to share the same belief system as their congregant. The other nine pastors stated they would allow the congregant to choose if they wanted to be referred to a professional counselor who shared the same belief system. One pastor stated it might be harmful to refer a congregant to a religious professional therapist if the congregant has been hurt by religion in the past. Furthermore, several pastors stated they would refer the client to whichever professional counseling was covered by the congregants’ insurance. One pastor stated he would feel more comfortable referring to a nonreligious professional counselor due to the lack of positive outcomes he has seen from congregants working with professional religious counselors. This finding was surprising given the literature revealed 41% of pastors stated that shared religious beliefs between the client and the secular therapist are “important,” and 15% of pastors stated those shared beliefs were essential when referring a client to a professional counselor.
(Farrell & Goebert, 2008; Stanford & Ross, 2015). Additional literature found pastors are more comfortable referring to secular counselors if they know the counselor has the same religious belief as they do and the congregant (Polson & Rogers, 2007; Vanderwaal et al., 2012). Future research could be done to determine the disconnect between current literature and the results of this research, which found pastors feel comfortable referring congregants to a secular counselor who does not share their own religious beliefs. This disconnect could be a result of the authors of this interview interviewing a small sample of pastors from a selected area in Northern California; however, further research could be done to explore why this disconnect exists.

**Collaboration between Professional Counselors and Pastors**

Literature revealed an increasing amount of evidence suggesting spiritual beliefs can have a positive role in a client's recovery thus making it crucial that pastors and secular counselors learn to collaborate in order to best help their congregants (Bledsoe et al., 2013; Bornsheuer et al., 2012; Butler & Zamora, 2013; Leavey et al., 2012; Sullivan, et al., 2013, Vanderwaal, 2012; Wood et al., 2011). Further, the Joint Commission on Accreditation of Healthcare Organizations requires healthcare professionals to assess spirituality and provide spiritual care when the client requests (Gomi et al., 2013). Therefore, it was surprising to the authors when they found that only four out of the eleven pastors interviewed have collaborated with a secular counselor. The authors found all four of these pastors confirmed this collaboration to be beneficial to their congregant. However, the researchers believe more studies need to be conducted to better determine the importance of collaboration between pastors and secular counselors and find out how
this collaboration could be better facilitated. Future research could be done to determine the barriers pastors and secular counselors face when trying to collaborate with one another and what bias they may have in collaborating with one another.

**Time Spent in Working with Someone with a Mental Illness**

Literature showed researchers that pastors reported spending approximately 15% of their time in pastoral counseling; however, through qualitative interviews the researchers found significantly different data. Surprisingly, only pastor number four stated he spends a significant amount of time working with someone with a mental illness. While the 10 other pastors stated they spent from five to zero hours working with a congregant with a mental illness a month. Additionally, research and the interviews revealed pastors are frontline responders to a congregant with a mental illness; therefore, it was surprising to the authors that only one pastor reported spending a significant part of his week working with someone with a mental illness. More research needs to be conducted to determine if pastors realize they are working with a congregant with a mental illness. Due to the finding, which revealed many pastors do not feel they have the education needed to work with or identify someone with a mental health disorder, it is hypothesized that many pastors are unknowingly working with a congregant with a mental illness. Furthermore, 10 out of the 11 pastors interviewed revealed wanting to be a part of the support system to a person with a mental illness.
Implications for Future Research

Due to the findings that emerged from this qualitative research study there were several implications for future research specifically for future policy development as well as future practice. These recommendations are discussed below.

Implications for Policy

Secular counselors have reservations concerning making referrals to pastors, especially when it concerns confidentiality. For example, pastors do not fall under the same Health Insurance Portability and Accountability Act (HIPPA) laws that counselors do (Butler & Zamora, 2013). The United States Constitution protects pastors from being sued for breach of confidentiality and allows them the freedom to decide what the ethical issues are surrounding confidentiality (Butler & Zamora, 2013). The American Association of Pastoral Counselors (AAPC) has a code of ethics that they operate under that closely resembles the National Association of Social Workers (NASW) code of ethics in regards to confidentiality (American Association of Pastoral Counselors, 2012; National Association of Social Workers, 2015); however, many pastors who are considered frontline mental health workers are not certified under the AAPC and therefore do not have to adhere to these standards. For example, the research found 11 out of the 11 pastors interviewed who participate in pastoral counseling have no association with the AAPC and therefore do not have any oversight regarding their limitations, confidentiality, ethical standards, or mandated reporting. These issues make collaborating with pastors more complicated. Butler and Zamora (2013) encourage collaboration; however, they strongly warn professionals to be aware of the limits of
confidentiality specific to the church and pastor working with the client. Policies need to be implemented by the mental health community to better help secular counselors know how to navigate when collaborating with a pastor to better help their client.

One pastor stated in his interview that he desired more training from the mental health community while another pastor revealed he believes denominations should be doing a better job at training their church leaders on how to work with an individual with a mental illness. Research could be done to determine the need for policies mandating continuing education on mental health for pastors. Additionally, denominations should conduct research to determine the benefit to congregants and pastors to have trainings on mental health available to them through their denomination.

**Implications for Practice**

Pastors who counsel congregants with severe mental illness must recognize their limitations. In the same way that a lifeguard may pull someone from the water who is in distress but knows when to call a more skilled professional, pastors must know that as frontline workers they are trained to encourage and minister, but not to diagnose and treat. While most pastors interviewed recognize their own limitations and will recommend medical experts to a congregant, the literature shows that their referrals are limited to those who share their faith (Farrell & Goebert, 2008; Stanford & Ross, 2015). A broader understanding of mental illness and acceptance of the benefit to the congregant for medical intervention would bring these two disciplines together to serve the congregant more holistically.
Pastors are educators as well as counselors. Much can be done in the way of pastors educating their congregations about mental illness to remove stigma. The more pastors preach about mental illness, the more they normalize it and show acceptance toward their congregants who suffer from it. Ongoing training offered by the National Association of Mental Illness (NAMI) to pastors and Christian counselors would be beneficial.

Seminaries could seek to be more responsive to the fact that one in five Americans struggles with a mental illness at one point in their life (National Alliance on Mental Illness, 2015). Rather than offering coursework solely as electives, seminaries and Christian colleges training future pastors should require students to take coursework on identifying and de-stigmatizing mental illness.

**Limitations of Study**

It is reported there are 600,000 pastors serving in various denominations in the United States. This figure includes retired pastors, pastors in hospitals, pastors in prisons and the military, and ordained faculty at divinity schools and seminaries. This number did not include independent churches, not tied to a denomination. However it has been reported there is no way to know how many pastors are currently practicing ministry in the United States (Hartford Institute for Religion Research, 2006). Out of the estimated 600,000 practicing pastors, the researchers interviewed only 11 pastors practicing in the Northern California area. Out of these 11 pastors, only one pastor identified as female and all 11 pastors were Caucasian. Further research needs to be done to interview pastors of various ethnicities and a larger population of female pastors.
Furthermore, a study done with a larger pool of data may yield different results than those found by these researchers. For example, this study found one aberrant case with a respondent whose responses were vastly different than the other 10 pastors. This reveals to the researchers that the sample collected is not representative of all the different mindsets of pastors when working with a mentally ill congregant. Additionally, the researchers utilized a convenience sample when contacting participants for the research. The personal relationship the researcher may have had with the participant could have influenced the participants’ answers through the course of the interview. The authors of this study are two Christian women seeking a master’s degree in social work. Due to this it is possible the authors role as the researchers may have affected the way they viewed the findings. The authors of this study discussed their findings with their non-Christian thesis advisor, Dr. Jenifer Price-Wolf, who agreed with the interpretations of the findings.

**Concluding Thoughts**

Despite the common goals of the church and the mental health care community, the historical relationship between faith communities and mental health includes conflict, mistrust, and even antagonism (Sullivan et al., 2013). More effort must be made to build bridges between church leadership and mental health professionals. In an effort to blend religion and mental health, many institutions have evolved out of a desire for more collaboration. Research centers studying the relationship between religion and mental health now exist at a number of universities including Duke’s Center for Spirituality, Theology, and Health, and the University of Chicago Program on Medicine
and Religion (Anderson et al., 2012). Other organizations have been formed to help decrease the stigma of mental health, such as NAMI, and, in the church, the American Association of Christian Counselors. Decreasing tension and increasing collaboration between pastors and mental health providers may improve treatment adherence for patients who are accessing both spiritual and mental health support (Sullivan et al., 2013). The literature shows ample studies concerning the need for and benefits of collaboration between religious leaders and mental health professionals. However, due to the lack of training pastors receive on the subject of mental health and confidentiality this collaboration has been minimal at best.

Through in-depth interviews, it was determined that all the pastors who participated in this study have worked with a congregant struggling with a mental illness making it necessary for pastors to understand their limitations and the role they play in a congregant’s life who is struggling with a mental illness. Every pastor interviewed stated they desired more resources and further training on the subject of mental health. Many pastors interviewed stated they would like a more collaborative relationship with secular counselors in order to better counsel the congregant. Additional partnerships could be created if churches allowed secular mental health providers to hold support groups at churches, allowed helping professionals to make short presentations in the church facility to the pastors and interested congregants, provided counseling services within the church, or hire a case manager to work with congregants with mental health concerns (Vanderwaal et al., 2012). The authors of this study conclude there are a lot of
multiple perceptions and differences in thought throughout the religious world regarding mental health.
Appendix A

Demographic Survey

1. What ethnicity do you identify with?

2. What gender do you identify with?

3. What is your highest level of education?
   
   i. If you have a college degree or higher, what is your degree in?

4. What kind of counseling/mental health training do you have?

5. How many years of experience do you have in this field?
Appendix B

Email Script

Mr. or Ms. ___ I am emailing to inform you about a study being conducted by Hailey Collier and Donelle Swain, Masters of Social Work students at California State University, Sacramento. As part of our requirements for graduation we must complete a research project related to the field of social work. Our study focuses on pastors and their experiences counseling congregants with mental health diagnoses.

This study will seek to help understand the perceptions, experiences, and service needs of pastors working with congregants with mental illness.

You have been identified as a pastor in the Northern California area who has face to face interaction with congregants who may be experiencing mental illnesses. We would like to set up a time for you to meet with one of us to conduct a thirty to forty five minute interview in order to answer the four questions listed above. There will also be a short demographic questionnaire at the end of the interview that will take approximately five minutes to fill out. All participation is voluntary and you can choose to revoke your participation at any time. All participation is confidential your name will not be attached with your interviews or surveys.

If you would like to participate in this study please email us to set up a time and date to be interviewed. If you have any further questions please feel free to contact us.

Sincerely,

Hailey Collier and Donelle Swain
Appendix C

Telephone Script

Mr. or Ms. ___ I am calling to inform you about a study being conducted by Hailey Collier and Donelle Swain, Masters of Social Work students at California State University, Sacramento. As part of our requirements for graduation we must complete a research project related to the field of social work. Our study focuses on pastors and their experiences counseling congregants with mental health diagnoses.

This study will seek to help understand the perceptions, experiences, and service needs of pastors working with congregants with mental illness.

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Would you like to participate in this study?
Appendix D

Implied Consent

Experiences and Perceptions of Pastors Ministering to Congregants with Mental Illness

You are invited to participate in IRB approved research which will involve a study of the experiences and perceptions of pastors ministering to congregants with mental illness in Northern California. Our names are Donelle Swain and Hailey Collier, and we are Graduate students at California State University, Sacramento, Social Work Department.

Your participation in this project is voluntary. Even after you agree to participate, you may decide to leave the study at any time.

The purpose of this research is to explore the experiences and perceptions of pastors ministering to congregants with mental illness. If you decide to participate, you will be asked to participate in a 30-45 minute interview. If you have any questions regarding this study please contact Donelle Swain at donelleswain@csus.edu or (916) 903-8098, Hailey Collier at haileycollier@csus.edu or (931) 374-7304, or their thesis advisor Dr. Jeniffer Price Wolf at wolf@csus.edu or (916) 278-6170. Risks associated with this study are not anticipated to be greater than those risks encountered in daily life. If you have any questions about your rights as a participant in a research project please call the Office of Research Affairs, California State University, Sacramento, (916) 278-5674, or email irb@csus.edu.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your
permission. In order to ensure your confidentiality all data obtained will be maintained in a safe, locked location and will be destroyed after a period of three years after the study is completed.

Your participation in this study indicates that you have read and understand the information provided above.
Appendix E

Semi-Structured Interview Guide

1. Please tell me about the type of ministry you do.
2. What is your conception of mental illness?
3. Can you tell me about a time you counsel to someone struggling with a mental illness?
   1. How did you determine that they were struggling with a mental illness?
   2. What kind of ministry do you offer people with mental health problems?
   3. How do you see your role in helping someone cope with and recover from a mental illness?
   4. On average how many hours a week do you spend counseling those with mental illnesses?
4. What resources do you typically utilize when you are working with congregants presenting with mental health challenges.
   1. What trainings have you attended or are available for you to attend?
   2. What is your comfort level referring to a non-Christian therapist versus a Christian therapist?
5. Tell me about a time you collaborated with a secular counselor?
   1. Was this beneficial to the congregant?
   2. What barriers do you see in collaborating with secular counselors
   3. What would make you feel more confident in counseling mentally ill congregants?
4. What are your strengths when working in this area?

5. What do you feel you are lacking to help you succeed in counseling congregants with a mental health disorder?
References


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