ALASKAN RURAL PASTORS' LIVED EXPERIENCES WITH MENTAL HEALTH STIGMA

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Department of Community Care and Counseling, Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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ABSTRACT

The purpose of this phenomenological study was to describe the lived experiences of rural Alaskan pastors with mental health and mental health stigma both personally and professionally. While there were few studies available to assist with the framework of this research there were some that focused on pastors, depression, burnout and collaboration with counselors in rural areas. A Conceptual Mapping Task (CMT) was used to conduct the interview of five pastors within an isolated Alaskan community. Pastors were asked to describe in detail their lived encounters with mental health stigma and how it impacted them and their congregation. Interviews were transcribed and examined for common themes which included; compassion fatigue, life struggles leading to ministry development and experiencing trauma and secondary trauma through family and friends.

Keywords: pastors, mental health, stigma, depression, burnout, counselors, collaboration

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Dedication

I would like to dedicate this study to pastors that are striving to bring the Gospel to Alaska rural areas. This is no small feat to accomplish when required to work in such a harsh and unforgiving environment. With nine months of winter, it is amazing that each continues to complete the work they do. Thank you for heeding God's call on your life and working diligently to usher people, even in these harsh temperatures, into the Kingdom of God. You guys are my heroes.

I would also like to dedicate this study to the mental health counselors in Alaska rural areas that continue to find ways to assist their clients and meet them where they are. For those willing to collaborate with pastors and others because you understand how vital it is to offer more than just your knowledge. Pastors and counselors working together will ultimately help our clients want to make lasting spiritual and mental health changes.

Acknowledgments

First, I want to thank Dr. King, my chair, for helping me get to this point in the process. I never believed that I would finish but he was the spiritual cheerleader I needed to keep pushing through. For that I am very thankful.

Secondly, I want to thank my husband, James, for being in my corner, not pushing, not pulling but just riding along beside me. You have been a huge part of this endeavor and I thank you for your support even when it did not make any sense.

Thirdly, I want to thank all the pastors that unwittingly jumped in with me and took the time to share your life stories. Your bravery is a testament to God's presence in your lives. Thank you from the bottom of my heart.

TABLE OF CONTENTS

Abstract 3

Dedication 5

Acknowledgments 6

Chapter One: Introduction 11

Overview.....11

Background of the Problem 14

Situation to Self 15

Problem Statement 16

Purpose Statement 17

Significance of the Study 18

Research Questions 19

Definitions 20

Chapter Summary 18

Chapter Two: Literature Review 23

Overview.....23

Theoretical Framework 24

Unique Cultural Aspects of Alaskan Life 27

Interior Alaska and Special Considerations 20

Military Bases and Fort Greely 30

Mental Health Stigma 31

Mental Health Stigma in Rural Alaskan Communities 33

Pastors and Mental Health Stigma 33

Religion and Mental Health Stigma 34
Barriers to Seeking Mental Health Assistance 35
Challenges to Providing Mental Health Support in Rural Areas 35
Removing Barriers to Mental Health Stigma in Rural Communities 37
Training Helps to Remove Mental Health Barriers 38
Origins of Mental Illness 40
Pastoral Beliefs About Mental Illness 40
Pastors as Gatekeepers for Mental Health Care 42
Pastors Collaborating with Mental Health Professionals 42
Many Sides of the Story 44
Pastors as a Mental Health Solution or Problem 45
Pastors and Compassion Fatigue 46
Pastors and Adverse Childhood Experiences 48
Chapter Summary 51
Chapter Three: Methods 53
Overview 53
Qualitative Phenomenological Design 47
Research Questions 55
Participants 55
Procedures 57
The Researcher's Role 57
Data Collection 58
Conceptual Mapping Task 58

Interviews....59
Surveys/Questionnaires....64
Document Analysis....64
Focus Groups....64
Observations....65
Data Analysis....65
Trustworthiness....67
Credibility....67
Dependability....68
Transferability....68
Ethical Considerations....68
Chapter Summary....69
Chapter Four: Findings....71
Demographic Data....71
Participant Profile Experiences....72
Pastor Buffalo....73
Pastor Red....81
Pastor Marie....88
Pastor Mike....99
Pastor Stockton....102
Results....112
Theme Development....112
Theme 1: Pastors' Challenges Lead to Greater Compassion....112

Theme 2: Experiencing Secondary Trauma....114
Theme 3: Pastors' Self-Care Prevents Compassion Fatigue....118
Research Question Responses....123
Chapter Summary....124
Chapter Five: Conclusion....125
Overview....125
Summary and Discussion of CMT Pastor Interviews....124
Theme 1: Pastor's Challenges Lead to Greater Compassion....128
Theme 2: Experiencing Secondary Trauma....128
Theme 3: Pastors' Self-Care Prevents Compassion Fatigue....129
What was Missing....130
Implications....133
Implications for Pastors....134
Implications for Counselors....135
Implications for Church Congregations....136
Delimitations and Limitations....137
Recommendations for Future Research....138
Summary and Conclusions....138
References....141

List of Figures

Figure 1: Pastor Participant Profile Graph ……....73

Figure 2: Pastor Buffalo's Conceptual Mapping Task ……..……...77

Figure 3: Pastor Red's Conceptual Mapping Task ……...…84

Figure 4: Pastor Marie's Conceptual Mapping Task ……...…….91

Figure 5: Pastor Mike's Conceptual Mapping task …….....99

Figure 6: Pastor Stockton's Conceptual Mapping Task……..107

List of Abbreviations

Adverse Childhood Experiences (ACEs)

Contextual Mapping Task (CMT)

Attention Deficit Hyperactivity Disorder (ADHD)

Chapter One: Introduction

Overview

> Be shepherds of God's flock that is under your care, watching over them—not because you must, but because you are willing, as God wants you to be; not pursuing dishonest gain, but eager to serve; not lording it over those entrusted to you, but being examples to the flock. - 1 Peter 5:2-3

In I Peter 5:2-3 a beautiful painting emerges of who a pastor is meant to be: a shepherd, exercising oversight without compulsion and eagerly serving as an example to all those within the flock. Not only is this a demonstration of humility and maturity but also a measure of mental health that requires a deep spiritual connection to God (Salwen, et al, 2017). However, in churches there could be a disconnect when a pastor is unable to see how their own mental health is impacting their congregation. In fact, pastors place themselves and their congregation at risk for further harm when they choose to ignore the mental health stigma that plays a role in their church community (Mathison, 2016).

The purpose of this study was to explore and evaluate the lived experiences of rural Alaskan pastors and mental health stigma. Generally, when someone in the church is struggling with mental health problems, they will most likely turn to their pastor for assistance, but if the pastor does not have the training or views everything as a spiritual issue, then the person seeking help will be limited. Using a phenomenological study can allow for a more personal view because it can obtain an exhaustive description of one's lived experiences through the pastor's own telling of their story (Heppner, et al, 2016). This could help to determine what motivated pastors or clergy as a whole when it comes to supporting their congregation and those who struggle with mental health issues (Bledsoe, et al, 2013). The information in this study could

assist both the counseling and the pastoral communities to determine better ways of championing their congregation and stamping out mental health stigma.

Background

Historically, limited studies have been conducted on pastors and their attitude towards mental health (Bledsoe, et, al, 2013, Salwen, et al, 2017)). There have been some studies on how pastors define mental illness or how emotional intelligence may play a role in the way a pastor leads the church (Makau-Olwendo, 2016). Other research has revealed the mental health stigma in religious communities by looking at what is missing within the church and how a congregation may be impacted when its pastor chooses not to look outside the walls of their church to help someone with a mental disorder (Mathison & Wade, 2014). Up to this point, a study has not been conducted that specifically looks at a pastor's lived experiences with mental health stigma, both personally and professionally.

In one sample, 204 Protestant pastors completed surveys about their treatment practices for depression. Payne's (2014) exact analyses revealed that more pastors with some secular education yet no degree felt that they were the best person to treat depression than pastors who had no secular education or pastors who had at least a secular bachelor's degree. However, the level of theological education did not influence beliefs about the pastor being the best person to treat depression either. In addition, neither the secular nor theological education level influenced pastors' views on referring people to mental health centers for depression treatment. In this particular study, the author had been able to explore these discussions to great length, allowing for an intimate view of what the pastors were thinking and feeling about each question. From it, some of the pastors were challenged to reconsider their own beliefs, and even one eventually went back to school to become a mental health counselor. This shows that a study of this nature

could change a pastor's worldview even if their main philosophy had been that prayer is the only recourse or that they have more than enough training to help with mental health problems.

In another article about the social complexities of mental illness, researchers aimed to explore the relationship between pastors and psychiatry in order to examine how clergy in various faith groups conceptualized mental health problems (Leavey, et, al, 2016). In this qualitative study using in-depth, phenomenological interviews, these topics were explored with 32 practicing clergy in the UK from a range of Christian, Muslim and Jewish faith organizations and ethnic backgrounds: 19 Christian ministers, 6 rabbis and 7 imams. The clergy, all men, aged between 37 and 68 years were English, African, African–Caribbean or South Asian (Leavey, et al, 2016). The findings of their research showed that even though each clergyman came from a different background, "they all held to the belief that mental illness was not attributable to spiritual influences only."

Situation to Self

This researcher grew up in a church that had a tendency to cover up the ugly things and hide what no one wanted to talk about. While working in the field of mental health counseling, I find myself witnessing other glaring atrocities because many pastors were unwilling to think outside of their own theological box. My hope is that this study will be a catalyst for other research that digs deeper into the world of pastors who choose to take on the role of mentally healthy leaders. They carry a huge burden yet are expected to lead with love and make Scriptural decisions. I believe there may be something missing within the context of their theological beliefs. Taking a look at their lived experiences may help move the Church to see more options when it comes to mental health care.

While living within the interior of Alaska, I have obtained first-hand knowledge of how ill-equipped some pastors are when it comes to mental health care. Many pastors are lacking in education and support either due to very few resources or an inability to understand the importance of mental health. There is clearly a need for a more robust study that could help determine the underlying reasons for the hesitancy seen in pastors who should be seeking the support for themselves and their parishioners.

As the CEO of the only counseling practice within a 90-mile radius of another agency, I have experienced sessions where clients have the deep-seated fear that they have let God down by seeking help. This is due to their church's teaching that counseling outside the church is somehow sinful. It is my hope that by focusing on rural Alaskan pastors, this current research could potentially open doors to studying other rural areas throughout the US.

Problem Statement

Pastors have been appointed as shepherds to care for God's people as compassionate leaders who care deeply for their community. However, the problem is that some congregations are looking to their church leaders for mental health assistance, but the pastor may or may not be in the best position to help. This could be due to a lack of education (Kpobi & Swartz, 2018) or possibly because the pastor believes all that is needed is Biblical knowledge (Mathison & Wade, 2014). According to research, however, this may not be enough (Payne, 2009). In fact, the pastor's perceptions of certain types of mental health problems could cause more harm than good, creating a stigma for those within the church, causing parishioners to believe that there must be something spiritually wrong with them because they are unable to just pray and make the pain stop (Simpson, 2013).

Evidence of this particular stigma has been seen within the congregation itself. Many times, those who are hurting will refuse to look outside of the church because the pastor feels that it is unnecessary and discourages his or her congregants from seeking help. It may also be that the pastor feels threatened by the idea of another person, especially if they are not a Christian or a church member. It is imperative that counselors and pastors work together so that they feel more comfortable with a referral from the pastor. Clients may also be reassured if they know that their pastor and the counselor are on the same page.

Another issue that has created problems is the high turnover rate of counselors within the Alaskan interior. Due to its cold temperature, dark winter days, lack of shopping, and few activities, most individuals are hard pressed to want to stay in such a severe environment. Those who are available usually were born and raised in the area and know what to expect. Others who try to make Alaska their home struggle to adapt to such a desolate place. In some ways coming to this part of the world is very much a calling, and a person has to be ready to make some major changes in their expectations in order to endure. However, pastors who are placed in the area find it a calling and may stay longer.

Purpose Statement

The purpose of studying rural Alaskan pastors is to understand the link between a pastor's life history and how it may have impacted the way he or she leads their church. This may help explain the pastor's choices when it comes to referring to outside resources for church members who are struggling with mental health issues. The research guiding this study is based on Payne's (2009) findings about pastors being first responders for people with immediate mental health needs.

In Payne's (2009) survey of 204 protestant pastors, the goal was to determine how clergy's views might shape their decisions about depression and a mental health referral to someone outside the church. The study examined clergy views on the definition and etiology of depression with the hypothesis that both clergy, race, and religious affiliation would play a significant role. They also looked at the education level, maturity level, socio-economic status, and the gender of each pastor.

Using the Clergy Depressive Counseling Survey, the results showed that a pastor's belief about the spiritual definition and etiology of depression could both facilitate and hinder treatment of those they served (Payne, 2009). They also determined that pastors with balanced beliefs in both the biological and spiritual aspects of depression served as advocates. Pastors who were limited in their views could potentially hinder growth or even alienate those who were struggling. They also discovered that some messages from the pulpit could inadvertently delay treatment for those who are suffering from clinical depression.

Significance of the Study

This study had three areas of significance to consider. The first is that there are no studies concerning rural Alaskan pastors' lived experiences with mental health stigma both personally and professionally. While there is some research about pastors or clergy pertaining to how mental health is perceived in the church, there is nothing specific about pastors' lived experiences with mental health stigma. A current understanding of what rural Alaskan pastors believe about mental health and what may be causing the stigma within the congregations may lead to the current paradigm shifting. Some Alaskan pastors specifically come to the interior because they do not need any type of training to preach, and they may tell their congregation that mental health issues are due to lack of prayer and Bible reading.

The second area of significance for this study is that there is a unique stigma within the Christian culture that contributes to congregations refusing to seek assistance outside the church despite the problems that exist, because they are discouraged by leadership for different reasons. Findings suggest that clergy can help if they think mental health extends beyond spiritual aspects to include biological and psychological (Mathison & Wade, 2014). Investigating how pastors in rural Alaska contribute to the stigma would help researchers to better understand the mind of pastors from this region.

The third area of significance is that if pastors are leaders that people will go to for immediate assistance when struggling with poor mental health, it stands to reason that individuals with mental health issues will have better outcomes (Zagoraski, 2014). This study could also help researchers to obtain a better idea of what is needed in the Alaskan rural churches, including the type of education or training. This and other information can contribute to research such as Payne (2009 & 2014) that could be extrapolated to other rural regions in the US and Canada.

Research Questions

In this phenomenological study, the goal was to obtain rich research nuggets about rural pastors' lived experiences with mental health stigma. This was obtained by asking the following questions:

1. *Q1- What are rural pastors' lived experiences with mental health stigma and what that might look like in their own lives as a leader of their church?*
2. *Q2- How might a rural pastor's lived experiences with mental health stigma influence the way they currently help their congregations' mental health needs?*
3. *Q3- How might rural pastor's lived experiences with compassion fatigue be impacting their view of mental health stigma?*

These research questions were used to guide the interview questions when speaking with the pastors. The Contextual Mapping Task, or CMT, was an in-depth interviewing tool and used during the interviews as a way to collect necessary information. The CMT assisted with data collection, allowing for open-ended questions that are usually not seen in qualitative studies (Heppner, et al, 2016). The use of the CMT helped the researcher to uncover different conceptualized processes that would not be found in a simple interview (Marin, et al, 1989).

Definitions

Bracketing. Bracketing is when researchers are careful not to place their own values on those who are being interviewed (Wertz, 2005).

Compassion Fatigue. Refers to an identifiable set of negative psychological symptoms that caregivers experience as a result of providing care while being exposed to either primary trauma (experiencing the trauma first hand) or secondary trauma (Figley, 1995).

Conceptual Mapping Task. Conceptual mapping is a tool used in research for interviewing that elicits rich data and methodological rigor (Impellizzeri, et al, 2017).

Data saturation. Data saturation means that there is no more data to obtain from the research (Fusch & Ness, 2015).

Epoch. Epoch in phenomenology studies means to set aside prior scientific assumptions or refrain from judgment in order to gain information. (Heppner, et al, 2016; Lindseth & Norberg, 2004; Wertz, 2005; Moustakas, 1994).

Member checking. Member checking is the verification that includes direct feedback from participants during a researcher's write up, allowing for thicker qualitative data (Impellizzeri, et al, 2017).

Phenomenon. A phenomenon is observable facts or data of interest (Heppner, et al, 2016).

Phenomenology. This is a type of qualitative research that focuses on the understandable meaning of lived experiences (Lindseth & Norberg, 2004; Moustakas, 1994).

Qualitative research. Qualitative research is about making meaning of experiences or phenomena by following the data as it emerges (Cruz & Tantia, 2016; Moser & Korstjens, 2017).

Secondary Trauma. Experience vicarious trauma from rendering care to those experiencing trauma (Figley, 1995).

Stigma. Process involving labeling, separation, stereotype awareness, stereotype endorsement, prejudice and discrimination in a context in which social, economic or political power is exercised to the detriment of members of a social group (Link & Phelan, 2001).

Structural description. Structural description is a term used in phenomenological research that refers to how an individual lived an experience (Lindseth & Norberg, 2004; van Manen, 2007)

Textual description. Textual description when used in phenomenological research is considered based on the nature by which the participant reported the experience (Lindseth & Norberg, 2004; van Manen, 2007).

Summary

The purpose of this study was to examine rural Alaskan pastors' lived experiences with mental health stigma, both in their professional and personal lives, and determine how these

lived experiences were impacting the advice they give and the choices they make, whenever their congregants approach them with a mental health need. Using the CMT along with three research questions explained the interaction between pastors and counselors in providing quality care for congregants of rural church communities. Since there are currently a limited number of studies, it was advantageous to conduct new research to understand what motivates a pastor when referring their congregation for mental health needs.

Chapter Two: Literature Review

Overview

The purpose of this study was to investigate Alaskan rural pastors' lived experiences with mental health stigma and how their experiences might influence the way they help parishioners who struggle with mental health concerns. The focus of this study was to address three main questions that could help determine the correlation between rural pastors' lived experiences and the mental health stigma in their churches. First, the primary goal was to establish rural pastors' lived experiences with mental health stigma and how it manifests in their own lives as church leaders of their church (Scott, 2018). A second goal was to determine how a pastor's lived experiences with mental health stigma can influence the way they currently help their congregations' mental health needs (Mathison, 2016). Thirdly, how might a rural pastor's lived experiences with compassion fatigue be impacting their view of mental health, and fourth, how do adverse childhood experiences play a role in a pastor's current mental health views within their churches (Wilkins, et al, 2017)?

Another focus point was how the origins of mental illness in rural cultures and traditions can cause a mental health stigma whether by the pastor, the church, or the congregation (Bryant, et al, 2104). Because many seek out rural pastors as gatekeepers to mental health care, the clergymen can experience compassion fatigue from carrying their congregations' heaviest burdens (Thomas, 2011). Finally, rural pastors' adverse childhood experiences or ACEs were inventoried and explained how these experiences impacted their choices to help or refer a congregant for mental health care (Burnette, 2016 & Wilkins, et al, 2017).

Theoretical Framework

The theoretical framework of a study is an important aspect of the dissertation process, and it is a component often missed due to the challenges of choosing the most suitable theory. The framework serves as a structure and support for the rationale of the study, problem statement, purpose, significance, and research questions while providing an anchor for the literature review and for the methods and results of the study (Grant & Osanloo, 2014). Another way to view theoretical framework is that it serves as a "blueprint" for the entire study, like that of a house created by an architect. There are many different types of theories to consider when selecting and "building" the structure, so it is important to consider with great care which theory or theories will help establish a firm foundation for the research (Grant & Osanloo, p. 14, 2014).

The theoretical framework that guides this study is Greenleaf's Servant Leadership Theory. According to Greenleaf (1977), "the servant leader is servant first… It begins with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead." Greenleaf was a retired director of management research at AT&T when he began writing about leadership, and after reading Herman Hesse's *Journey to the East,* he devised a not-so-popular thesis "that more servants should emerge as leaders or should follow only servant-leaders" (Greenleaf, 1977, p. 24). Greenleaf continued by saying:

> The difference manifests itself in the care taken by the servant-first to make sure that other people's highest priority needs are being served. The best test, and difficult to administer, is this: Do those served grow as persons? Do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants? And, what is the effect on the least privileged in society? Will they benefit at least and not be further deprived (p.27)?

While Greenleaf did not profess to be a Christian, it was obvious that he wanted to see change in how leaders worked in the secular world. He had hoped that this theory could help others make that change. Better yet, servant leadership has a clear biblical application for pastors and Christian leaders that starts with Jesus and runs through the New Testament of the Bible. In fact, because servant leadership has received a lot of attention in both the secular and Christian world, there is more weight added to the notion that to be a successful leader, one should be a servant leader (Cincala & Chase, 2018).

It is clear in Scripture that Jesus came to serve and not be served. Specifically, in Philippians 2:3-7 (ESV) it reads:

> Do nothing from selfish ambition or conceit, but in humility count others more significant than yourselves. Let each of you look not only to his own interests, but also to the interests of others. Have this mind among yourselves, which is yours in Christ Jesus, who though he was in the form of God, did not count equality with God a thing to be grasped, but emptied himself, by taking the form of a servant, being born in the likeness of God.

Continuing in verse 8, is the best explanation of the opposite of selfish ambition:

> And being found in human form, he humbled himself by becoming obedient to the point of death, even death on a cross.

It stands to be repeated that Jesus came to serve, not be served. This is what pastors have been called to do. Meaning that when pastors are serving their congregation, it does not end with spiritual needs, but physical and mental health needs must be included. The theoretical framework of servant-leadership may be what fuels this study, but the purpose that truly motivates the research is to reduce mental health stigma in the church. Mental health stigma in

the church may eventually become a thing of the past. However, this is only if pastors are leading with a servant's heart, just as Jesus exemplified in Scripture, then they too will be able to offer humble assistance to those in the church and community by living out the principles of Philippians 2 by taking the posture of a servant, just like Jesus. God's church is a place for everyone, and with a real servant-leader at the helm of His church, true worship and sweet fellowship can be experienced.

Gene Wilkes (1998), author of *Jesus on Leadership*, introduced a set of principles that reflect the servant-leadership model: 1) Humble your heart; 2) First be a follower; 3) Find greatness in service; 4) Take risks; 5) Take up the towel; 6) Share responsibility and authority; and 7) Build a team (p.25-27). He continues with an explanation of these principles:

> Jesus never sought earthly recognition. He came to carry out the mission his Father had given him. Humble service to his Father defined the life of Jesus. Real servant leadership begins when you decide to learn from and follow the real Servant Leader, Jesus Christ. (p. 55).

Just as I Peter 5:2-3 paints an exquisite picture of what a shepherd means in the New Testament church, so does Philippians 2:3-8 create a wonderful image of what a servant leader ought to look like. Both the words "shepherd" and "servant-leader" work interchangeably. Both have Jesus as the common denominator. Pastors that choose to lead shepherd/servant-leader are not seeking to make a name but rather follow Jesus in word and deed. There is no better way to serve Christ.

The rest of chapter two will focus on aspects of Alaskan life and how it can impact congregations, their pastors and mental health. There are many considerations that come to light when looking at how Alaskan pastors help others. Rural living is already difficult, but adding in

isolation and freezing temperatures, one would be hard pressed to believe that this type of living is something people actually choose to do. It is those pastors that show servant leadership, living in a rural, isolated town that can truly embody who Christ is within the interior of Alaska.

Unique Cultural Aspects of Alaskan Life

Alaska is the largest of 50 states, and because of its size, it has wide diverse geographic and demographic characteristics that can impact public health in many ways (Lengdorfer, 2017; Cohen, et al, 2018). As of 2016, the population was 739,828 with about 586,412 square miles of land with unique climatic conditions that can range from severe highs of 100 degrees to lows of -80 degrees (Lengdorfer, 2017). In Alaska, people live in extremely remote areas with some towns having no more than 1,000 people within 100 square miles of land (Flora, et al, 2016). These small populations require its people to rely on one another, but at times the isolation and lack of resources make it difficult to fill the void for those who are looking for help (Donlon & Williams, 2018).

Interior Alaska and Special Considerations

The vast interior of Alaska consists of mostly rural towns and miles in between where there is nothing other than trees and roads. While the majority of Alaska's population centers are not connected to an existing road system, within the interior there is one main road, and it starts with the Canadian border and follows through Tok, Delta Junction past Big Delta, Salcha, North Pole, and into Fairbanks (Travel Alaska, 2020). Transportation between these towns requires many hours of driving with very few gas stations in between. The state of Alaska defines *rural* as "a community with a population of 5,500 or less that is not connected by road or rail to Anchorage or Fairbanks, or with a population of 1,500 or less and still connected by road or rail" (State of Alaska, 2020).

Delta Junction, also known as Delta, is the last town on the Alaska Highway and was built during WWII to connect the United States with Alaska (City of Delta, 2020). On a clear day one can see the Alaska Range from Delta Junction with Mt. Hayes being the highest visible mountain on the horizon at 13,832 feet (State of Alaska, 2020). There was a small IGA downtown, but it was recently destroyed by a winter storm and now the liquor store has some groceries. There are three gas stations, one post office, two hardware stores, a public health office and one counseling practice. The two medical clinics in town are serviced by a private emergency medical transport company. Delta is considered to be a rural town with fewer than 1000 people in the community, and with few resources available at times, it can seem rugged and unpredictable. However, while most community members are used to these conditions, when there is an emergency of any kind, those resources seem extremely restricted, especially when the nearest hospital is 90 miles away.

For many who live within the interior, there are some other things that influence the status quo. The winters last about 9 months, and for most the darkness can be very trying. Starting in September, the dark days become longer and longer, and by December 21st, Winter Solstice, it feels as though there are 24 hours of darkness with a few hours of dusk in the middle of the day. In addition, several feet of snow can accumulate with blizzards that blow in and out within days of each other. Then there are the Delta winds that can make the temperatures drop to 40 below zero or colder depending on the time of the year (Travel Alaska, 2020).

Most individuals, especially within the interior, begin to experience the long dark days with symptoms of constant weariness, lack of motivation, ruminating negative thoughts, and extreme sad feelings that just will not go away. Some may even experience suicidal ideations because they have been unable to get a handle on the depressive thoughts. Many individuals

who experience these symptoms might also be diagnosed with seasonal affective disorder or SAD and, based on the DSM-V, would probably meet the following criteria: (1) at least 2 years of having more seasons of depression than seasons without depression and (2) meet the criteria for depression that begins and ends during a specific season every year (American Psychiatric Association, 2013).

In a sample study of 283 adults living in Fairbanks, Alaska the goal was to determine just how prevalent seasonal affective disorder (SAD) was within the interior (Booker & Hellekson, 1992). Using the Seasonal Pattern Assessment Questionnaire, the researchers were able to rate changes in mood, sleep length, social activity, weight, appetite, and energy levels. They also used the 20 item Center for Epidemiologic Studies Depression Scale (CES-D) to determine the frequency of depressive symptoms over the previous week. The results of these two assessments showed that one in four residents of Fairbanks were adversely affected by the dramatic seasonal changes occurring within the interior, and nearly one in ten were severe enough to be given a diagnosis of SAD (Booker & Hellekson, 1992).

What some do not understand is that SAD is treatable because there are a few things going on within the human body that can be treated with either medication or other types of mixed therapy. According to one review article, individuals with SAD have difficulty with an overproduction of melatonin which can make them feel lethargic and sleepier due to the lack of sunshine (Melrose, 2015). Then with the combination of less serotonin caused by the decrease in Vitamin D from the sun, and the increase of melatonin, the circadian rhythms become disrupted, making it difficult for the body to adjust to the change in season (Melrose, 2015). It is the perfect storm. However, the use of light therapy, or "happy lights," plus Vitamin D supplements can offer a substantial advantage (Krakow, 2019). Add that to exercise, being outside, and

staying social, and one has several resources that can contribute to feeling better (Krakow, 2019). Unfortunately, some rural pastors are unaware of these problems or of the fixes that could be applied to help their congregation because of the mental health stigma that is attached to SAD and other diagnoses.

Military Bases and Fort Greely

Several military bases have been built in Alaska since 1867 (U.S. Army, 2020). The closest military base to Delta Junction is Fort Greely, about 10 miles south on the Richardson Highway. Fort Greely's mission as a midcourse missile defense and a cold region test center brings many jobs to Delta Junction (U.S. Army, 2020). Fort Greely is a U.S. Army garrison with Active National Guard soldiers as well as Department of Defense (DOD) workers, which ensures training and operations are up and always running. While Fort Greely offers opportunities, it also brings with it soldiers and veterans who suffer with post-traumatic stress disorder (PTSD) and continue to experience many types of anxiety and depression that need professional treatment (Coleman, et al, 2017).

Fort Greely offers many resources to a resident of Delta Junction as long as they are a soldier, U.S. veteran, or a government worker. There is a Military Family Life Worker for soldiers and their families, but it is a short-term position, and their goal is to make referrals (MilitaryOneSource, 2020). There is also the chaplain who is assigned to each unit for soldiers and their families. However, if a mental health stigma is held within a particular unit, a soldier may already believe they need to handle their issues on their own. A chaplain can either encourage the soldier to seek help or keep them from getting it (Elbogen, et al, 2013). Those who live on or off post and attend a church within the Delta community may also be seeking assistance for their mental health needs. Pastors and chaplains who hold views riddled with

stigma may be a bigger source of confusion than help, so it is important they all understand what is needed so changes can be made.

Mental Health Stigma

Before moving on to mental health stigma and how it is portrayed in rural Alaskan communities, it is important to understand how *stigma* is defined and the way it can impact those who struggle with mental health issues. While there have been many different articles published on stigma, it is Link and Phelan's (2001) influential review of conceptualizing stigma that aptly defines the concept of stigma. The authors noted that while the definitions themselves vary, there are two reasons why this may come about. First, each situation is unique and would lead investigators to conceptualize stigma in a different way. Secondly, since the term *stigma* is multidisciplinary, many researchers will approach it with a different theoretical orientation, and this could produce other frames of reference when defining the word *stigma* (Link & Phelan, 2001).

With that being said, and for the sake of the current research, the following will be used, per Link and Pelan's definition, as the four processes of stigma: (1) labeling human differences; (2) stereotyping such differences; (3) separating those labeled from "us;" and (4) status loss and discrimination against those labeled (Link & Phelan, 2001, p. 367). According to Clair (2018) by using power and discrimination in their definition, Link and Phelan (2001) articulated an approach that allows researchers a way to understand how stigma relates to social creation, reproduction, and social inequalities. All of this can help each researcher understand how stigma impacts not only the individuals but also those whom they encounter on a daily basis.

Taking the term *stigma* and adding it to mental health then changes how one views what mental health is and how it becomes a perceived negative belief based on that of one's own

perspective (Mathison, 2016). This belief is then broken down into two concepts known as both public stigma and self-stigma (Mathison, 2016). Public stigma includes stereotypes, prejudice, and discrimination of those who may be labeled as mentally ill. Self-stigma occurs when an individual with mental illness internalizes that public stigma, and it leads to lower self-esteem and a lack of self-efficacy. In fact, stigma and mental health becomes intimately tied when someone is trying to decide whether they choose services for their own mental health or decide that they are better off without it (Wu, et al, 2017).

There are two mechanisms at work when it comes to mental health stigma. First, stigma can decrease the possibility of mental health services and even exacerbate those with poor mental health. Secondly, the combined effects of stress due to internalizing a stigmatized identity can also cause mental health issues to become worse (Wu, et al, 2017). Other experiences likely to impact stigma include race/ethnicity, gender, and culture. Also, in rural Alaskan communities, there is a mental health stigma that is promoted within individual tribes making it next to impossible for Alaskan natives to believe that they should get the help that they need (Freitas-Murrell & Swift, 2015).

Mental health stigma is also a character trait where someone with a mental illness may be deemed ignoble and because of this will want to conceal their illness to avoid discrimination (Mathison, 2016). This, unfortunately, will only stop people from getting the help that they truly need. People with other stigmatizing character traits, like being an ex-convict or an addict, can avoid outside discrimination and self-evaluation by denying the fact they have a mental illness at all. However this will have profound implications for mental health treatment and slow the process for those who do ask for assistance, especially if the resources are not available (Mathison, 2016).

Mental Health Stigma in Rural Alaska Communities

It is common knowledge that rural residents are facing substantial barriers to mental health care due to the shortage of mental health providers in their community (Weaver, et al, 2019). While there may be one or two providers available, the rural area may lack other specialists such as a psychiatrist, psychologist, or even a licensed professional counselor (Hoeft, et al, 2018). Usually, these areas will have a family doctor available and thus making their physician responsible for all their physical and mental health needs. Unfortunately, even a family doctor is limited by time and resources (Hoeft, et al, 2018). However, within the rural area, there is usually a pastor or clergyman available, and they may be able to offer more time than a medical doctor (Weaver, 2019).

Pastors and Mental Health Stigma

Pastors carry a mental health stigma of their own into their ministry. Depending on their family system, religious beliefs, understanding of the Bible, and their overall worldview of Christianity, pastors have established their own set of beliefs about mental health based on their lived experiences (Mathison, 2016). For some, there is the belief that people just need to pray more, read Scripture frequently, or simply trust that God is going to take care of them (Payne, 2009). Some of these pastors have grown up in extreme fundamentalist backgrounds that teach that anyone with a mental health problem is not following God's requirements, thus they are being punished for their choices and are meant to suffer (Peteet, 2019).

For other pastors, the problems associated with mental illness are closely related to the destruction of traditional values, individualism and the erosion of the family and community, materialism, lifestyle and the loss of authority; or in clergy terms, a breakdown of structures that are imbued with and informed by religious values (Leavey, et al, 2016). It is these pastors that

may lack the education needed to help their congregants in such difficult situations (Payne, 2014).

Religion and Mental Health Stigma

Church congregations can also hold a mental health stigma that covers a spectrum of different walks of life. Cultures, beliefs, life experiences, and other members of the congregation's mental health problems can also create a stigma that may keep people from getting the help that they need (Peteet, 2019). Some common religious beliefs indicate that the main causes of mental illness can include moral weakness, sin, unfaithfulness, not reading the Bible, or not attending regular worship (Mathison, 2016).

However, if the afflicted person attends a church that clings to a mental health stigma, then they will not notice there is an issue until they experience a crisis and are unable to get the assistance that they need because ministry leadership continues to insist that the individual just needs to pray or read more Scripture. Other beliefs about mental illness include insisting that depression or anxiety is just a moral weakness that needs to be prayed through (Mathison & Wade, 2014). For some churches, the first theological diagnosis is the possibility of demonic influence that needs to be exorcized (Mantovani, et al, 2017).

In a study about how attitudes towards people with mental illness affected personal beliefs, 305 university students from Italy and Israel were analyzed looking at the difference between religious beliefs, cultural background, physical danger, social closeness, and public avoidance (Mannarini, et al, 2018). Instruments used included the Community Attitudes to the Mentally Ill, the Questionnaire on the Opinions about Mental Illness and The Attribution Questionnaire-27 as well as the Mental Disorders Causal Beliefs Scale and the Mental Disorder Therapy Relationship scale (Mannarini, et al, 2018). The results of the research demonstrated

that someone with a mental illness could be considered dangerous or undesirable. This belief could be the result of religious beliefs or background; however, the results changed based on relational or personal knowledge of the illness (Mannarini, et al, p.7). From this study, three religious stereotypes were discovered when one has contact with someone diagnosed with a mental disorder like schizophrenia. Those stereotypes included demonic possession, mental illness as a punishment from God for moral weakness, and a consequence of insufficient faith in God (Mannarini, et al, p. 1).

Barriers to Seeking Mental Health Assistance

Before barriers can be removed, it is important to understand what they are made of in the lives of individuals with mental health problems in rural areas. Specifically, without the aid of other professionals or dramatic policy changes, rural communities will continue to struggle to have adequate quality mental health care and service providers (Hall & Gjesfjeld, 2013). Many of these rural areas have limited access to services because mental health counselors, along with other professionals in rural areas, have a high turnover rate impacting the therapeutic relationship (Hall & Gejesfield, 2013). Another result of the high turnover rate and inconsistent counseling is that facilities have a restricted number of days each week when they are open to the public. Plus, some individuals will still need to travel outside the community in order to receive consistent care or any care at all.

Challenges to Providing Mental Health Support in Rural Areas

Common barriers for those seeking help include scheduling appointments where the individual is unable to take time off or works every work day and is unable to make an appointment (Haugen, et al, 2017). Additionally, they might not know where they can get help because they are unsure where to start or are discouraged by other people about asking (Haugen,

et al, 2017). Then they may have trouble getting time off because they need to make an appointment during their shift but may not have the option or are fearful that this could impact their ability to successfully do their job (Coleman, et al, 2017). Additionally, they may have a supervisor who discourages treatment altogether because of their own lack of understanding, thinking that the employee just needs to buck up and do their job (Coleman, et al, 2017). All of these factors create huge barriers for those who are in need of mental health services making it a challenge for rural residents to get the help as needed (Hall & Geisford, 2013). Finally, when someone does realize the need for help, these barriers make it extra difficult to get the assistance that they need.

According to Britt and associates (2012), practical barriers that emerge for those seeking help can include embarrassment, harm to one's career, and loss of confidence by their leadership. In one study, 1,455 active-duty soldiers were assessed using a perceived stigma and practical barriers questionnaire to research decisions in seeking mental health care (Britt, et al, 2012). What they found was that leadership behaviors had a huge impact on military personnel, showing that negative/destructive leaders were closely linked to mental health stigma whereas positive/constructive leadership was linked to more practical barriers (Britt, et al, 2012). When practical barriers were the only issue, a leader who exhibited positive leadership skills was more likely to help remove those barriers and accommodate the soldier's needs (Britt, et al, 2012).

Other mental health barriers included fear of services not being confidential, that seeking services would have a negative impact on their career, or even judgment from coworkers and supervisors (Haugen, et al, 2017; Martin & Giallo, 2016). Both mental health practitioners and pastors have an opportunity to help the individual. However, if those offering help are evincing

certain fears that come from their own past events, it stands to reason that anyone seeking help would be hesitant to reach out which may exacerbate their mental health issues.

Removing the Barriers of Mental Health Stigma in Rural Communities

According to some researchers, one way to remove these barriers is by clergy to close the mental health gap, but their success depends upon their ability to recognize when referrals to formal mental health professionals become necessary (Vermass, et al, 2017). The problem has been that current mental health referral patterns by pastors throughout the United States seem to be rare even though they report that referrals are being made (Vermass, et al, 2017). Other concerns include those with severe mental illness who receive informal treatment or do not receive treatment at all (Mannarini, 2018). This is when interprofessional collaboration would be most useful, making it a viable option to help remove the barrier between the church and those in the mental health profession (Bledsoe, et al, 2013). The ideal situation would be for counselors and pastors to work together (Thomas, 2011) and possibly reduce mental health care disparities (Vermass, et al, 2017)

A pastor could be a good fit for mental health care because most individuals feel comfortable consulting their clergymen for other issues. Even though pastors are not mental health providers, religious leaders have responded to unmet mental needs in rural communities for generations and have become an increasingly more attractive option for those seeking assistance for mental health-related issues (Hall & Gjesfjeld, 2013). It is these same pastors who are often called to a person's home when someone is sick or to the hospital when one is dying, and even to the sight of an accident whenever a person needs comfort. However, some of these pastors may be lacking in mental health training and consider this an area in which they need more training (Hall & Gjesfield, 2013). While they may offer all things spiritual, their training

may be limited when confronted with someone who suffers from a mental illness or when someone is in the midst of a suicidal or homicidal crisis (Bledsoe, 2013). A pastor without the correct training could make things worse if they send that person home to pray instead of referring them to the ER or on-going services (Mathison & Wade, 2014). This may also result in needless suffering or a tragedy that could have been avoided.

There are different mental health organizations that are making an effort to mitigate these challenges by offering resources either via phone or on-line (Holland, et al, 2018). There are also counseling practices within rural areas that offer more telehealth options for those who are willing to reach out beyond the walls of their community and feel comfortable with using this type of technology (Holland, et al, 2018). Due to the recent outbreak of COVID-19, there is now an even greater need for tele-mental health to be available throughout every part of the United States, especially the rural areas (Glanz, 2020). However, there are still those who continue to seek out in-person assistance and are looking for a professional to assist them with their mental health needs. Since others would prefer to see someone in person, there is still the need for rural pastors to overcome the stigma they exhibit when it comes to the mental health crisis.

Training Helps to Remove Mental Health Barriers

Research has shown that leaders who receive training shared more information about mental health and actively encouraged their employees to use available resources (Dimoff & Kelloway, 2019). If this is the case, then it is possible to conclude that the more information pastors have about mental health, the more likely they will be to make a referral. That leads us to something Vermaas, and associates (2017) discovered in their study about mental health literacy of the clergy. Their research showed that there were some pastors who had the education and knew what the options were but still chose not to refer. However, in a social media study by

Payne and Hays (2016) where 35 pastors discussed freely among themselves how to assist people who are depressed and suicidal, one pastor who originally believed referrals were not necessary decided to attend further schooling, eventually got a degree in counseling, and changed his perspective about mental health for the better (Payne & Hays, 2016). This is hopeful because it means that viewpoints can be changed when someone is faced with a different ideal from the one they have been taught.

Two types of training were mentioned in the literature. One was called Resource Utilization Model (RUM) and the other was recognized as SOS or Signs of Struggle. Both were used to help business leaders recognize warning signs, promote mental health and support mental health needs (Dimoff & Kelloway, 2017 & 2019). Training for these leaders included: how to address concerns, how to support the employee, how to suggest resources, and how to navigate disabilities (Dimoff & Kelloway, 2019). Other training could include the collaboration of pastors and mental health professionals learning together about how they would help those in their community as a team (Thomas, 2011).

In another study of 204 pastors using the Clergy Depressive Counseling Survey, 77% surveyed felt that it was either always, almost always, or occasionally appropriate to refer depressed people to a mental health center (Payne, 2014). In contrast, 23% of pastors did not feel that referring to a mental health professional was the best choice. However, 77% of the 204 pastors said that they would be interested in further training about depression, but the demographics statistics showed that those who were in lower socioeconomic status (SES) communities were more likely to seek training than those who were in higher SES communities (Payne, 2014). Based on these results there is a possibility that when offered, pastors in rural areas of Alaska may be willing to consider training of some kind.

Another type of training that has shown to be advantageous for leaders is emotional intelligence (EQ) (Breadberry & Greaves, 2009). In a study of two groups, the group receiving EQ training scored significantly higher on trait emotional intelligence, emotion identification, and emotion management after the program was complete than the group that did not receive any training (Neils, et al, 2009). This shows that any education for pastors or clergy that excludes EQ is doing them and their congregation a disservice (Makau-Olwendo, 2016).

Origins of Mental Illness

Research has also shown that some believers feel mental illness is a result of sin and can only be cured by prayer (Mathison & Wade, 2014; Mathison, 2106). Others believe that one needs to somehow acquire more faith if they are experiencing mental health issues (Mantovani, et al, 2017). Then there are others who believe that mental illness, like depression or anxiety, is simply a moral weakness that can only be solved via reading Scripture (Mathison & Wade, 2014). While others think it is caused by a demonic influence that needs to be exorcized (Mantovani, et al, 2017; Bryant, et al, 2014).

Some spiritual traditions indicated that the main causes of mental illness include being unfaithful to God, not reading the Bible, or a lack of church attendance (Mathison, 2016). Some view the problem as being about reducing mental illness to just bad feelings that someone needs to get over. This viewpoint assumes that there is no room for biochemical imbalances or trauma-induced states, and it is all simply lumped together with sin, not an illness but a flaw (Morris, 2018).

Pastoral Beliefs about Mental Illness

In one study of 238 Christian clergy by Vermaas and associates (2017), they discovered that most clergy patterns of non-referrals were not due to their lack of mental health literacy but

rather because of other factors such as spiritual beliefs, culture and access. Using the web-based version of Mental Health Literacy Scale, 35 questions were administered to determine a pastor's educational background in mental health and how it might impact their willingness to refer (Vermaas, 2017). There may be other reasons like background or trauma that can be discovered when looking at a pastor's lived experiences with mental health and that impact a pastor's desire to refer.

Pastors from different religious denominations can have differing beliefs about the underlying causes of mental illness that can significantly affect attitudes, referrals, and coordination with mental health providers (Bledsoe, et al, 2013). In an interesting study by Payne and Hays (2016) of an online conversation between 13 clergy over a period of 13 days, the following question was asked; "If the church is where we go for healing, how do we handle people who are depressed, suicidal, suffering from PTSD or anxiety (Payne & Hays, 2016, p. 602)?" The implication of the results showed that differing beliefs as well as life experiences played a huge role in how each person responded to the topic at hand.

In another clergy study that was conducted by Payne (2009) the goal was to determine how pastors perceive the definition and etiology of depression. Using both emailed and mailed surveys for 204 Protestant pastors in California it was discovered that for some African American pastors, depression was a moment of weakness when dealing with hard times, but Caucasian pastors were more likely to consider depression as a biological mood disorder and mainline Protestants frequently disagreed with statements about spiritual causes of depression versus Pentecostals and non-denomination. This study showed that pastors seem to be affected by several factors to include race and denomination, but mostly they were influenced by their religious affiliation (Payne, 2009). Pastors who are limited in their views of mental health can

hinder growth but those who are able to utilize their spiritual expertise and refer out are more effective spiritual advisors for all aspects of their congregation (Payne, 2009).

Pastors as Gatekeepers for Mental Health Care

In another more recent study of 379 survivors from 9/11 it was found that personal severity of the disaster experience was associated with greater religiosity/spirituality especially if disaster trauma exposure, injury in the disaster, perceived upset and harm, and psychological injury occurred (Hong, et al, 2019). Structured interviews were administered with three different agencies that had been housed in the WTC towers during the time of the attacks using two instruments: the Disaster Supplement and the Diagnostic Interview Schedule (Hong, et al, 2019). The results showed that those who considered religion and spirituality important were more likely to reach out for religious support from their pastors (Hong, et al, 2019)

In most congregations, the pastor is considered to be the front-line mental health worker because he/she assists with funerals, baptisms, marriages, marital problems, and personal crises in the lives of those who trust them. Since there is usually no stigma attached to a pastor about emotional concerns, individuals are more likely to reach out to their religious leader (Payne, 2009 & 2014; Payne & Hays, 2016). A shortage of behavioral health workers means the need to outsource this service to nontraditional vocations makes sense, but it also means there is a need to determine attitudes and incorporate training to ensure that no one is harmed in the process of being helped (Payne & Hays, 2016).

Pastors Collaborating with Mental Health Professionals

Studies have shown that the collaboration between mental health providers and clergy are somewhat lacking due to several obstacles to include communication and educational awareness (Thomas, 2011). In the past, there has been little understanding as to what types of collaboration

are needed between mental health professionals and pastors that could be useful, but it is necessary to provide both spiritual and psychological support (p. 100).

In a study by Thomas (2011) that focused on communication between the church micro-system and mental health service micro-system, the author surveyed 149 pastors looking at personal and professional characteristics to determine what types of collaboration would be helpful. What the study identified was that academic education and interprofessional education had a huge influence in the relationship between clergy and mental health professionals. The results also showed that when the two sides collaboratively trained and worked together to obtain a common goal, everyone benefited.

Looking at these two significant variables, academic and interprofessional education, it is important to understand how they played a role in this partnership during the study. First, interprofessional collaborative practice involved pastors and mental health workers exchanging information such as referrals, coordinating services and planning joint responsibility. Secondly, academic education covered ongoing higher-level learning about mental health, and pastors with lower levels of education correlated with lower levels of interprofessional collaboration. This positive relationship between the two variables suggests that participation in collaborative practice can increase academic education, trust, teamwork, and communication skills (Thomas, 2011).

Some good examples of this type of training could include addictions or domestic violence to not only allow for collaboration through an avenue of education but also give pastors and mental health counselors an opportunity to work together in a non-threatening way. If clergy and mental health professionals are already coming from within the same rural town or area, then it stands to reason that something such as training together would offer a more cohesive option

that opens up healthier communication. Pastors are less likely to refer if they do not know who the professionals are that they are referring to because they feel personally responsible for those that God has placed within their congregation. As mental health counselors, we must be sensitive to that. It is the only way we can create the collaboration that is necessary to help our clients.

Many Sides of the Story

There are two sides to the coin as to what motivates a pastor to refer or not refer. In one case study by Gilgun and Anderson (2015) they interviewed four mothers who asked for help from their pastors after discovering that their husbands had sexually abused their children. Two of those pastors responded by contacting the police and getting the mothers the help that they needed even if it was not a popular choice. These pastors also referred them for mental health counseling and were available to all the family members. Even though the mothers were upset that the pastors had contacted the police, they realized later that it had to be done for everyone to be safe again.

On the other hand, two of the women who sought assistance from their pastors were not so fortunate. One of the women was already seeing a licensed Christian counselor that worked for her church but was telling her that she was destroying the marriage with "those kinds of thoughts" (Gilgun & Anderson, 2015, p. 686). Then she tried talking with both the pastor and his wife and they too were unsure what to say or do and did nothing to help. The woman eventually left the church and after her husband was jailed; she switched churches. When the time was right, she went back to the church that was unable to help and confronted the pastor and his wife. They both apologized and were receptive to making the necessary changes.

The fourth woman was not so fortunate. When she went to her pastor for help, the problem was pushed back on her and she was told that she was not being submissive enough. Then the pastor told her that if she would just "satisfy her husband sexually" (Gilgun & Anderson, 2015, p. 688) there would be no problems. When they asked her about being physically abused, she was fearful to tell the truth because she was being terrorized by her husband and did not have a safe place to go. In the end, she left the church, and if it had not been for her parents' support, things would have been even worse.

The study by Gilgun & Anderson (2015) shows two sides of the coin, but some pastors who choose not to offer counseling referrals are basing their decisions on their own personal experiences. In one phenomenological study that included 8 rural African American pastors, a few participants had negative experiences with mental health providers. This was because there was no therapist who met their standards and specifically, were only advocating for Christian counselors. This kept them from referring their congregation to any counselors.

In a qualitative study of 347 youth and campus pastors, participants were asked how likely they were to collaborate and refer to mental health counselors in their area (Hunter & Stanford, 2014). The results showed that 64% of the respondents had collaborated with a mental health professional and were very likely to do so again in the future. But 100% of those who participated wrote that the primary barrier to working with counselors was the lack of connection to mental health professionals and differences in religious beliefs.

Pastors as a Mental Health Solution or Problem

There is a possibility that pastors who have a need for control, are overly stressed and less familiar with mental health concerns would be less likely to refer congregants to counseling. In a study by Martin and Giallo (2016) it was found that stigmatizing attitudes towards depressed

employees were higher among supervisors who had more internal need for control, had higher levels of stress, and were less likely to refer their employees to counseling.

As mentioned earlier in a study by Vermass and associates (2017), there was a disconnect between a pastor's understanding of mental illness and their referral behaviors, showing that even though they had high mental health literacy (had taken some counseling classes), they were not willing to collaborate with the mental health community because they felt that they had already learned what they needed to know to help their congregation. In other words, they did not need to refer because they felt that they were well trained with what they knew.

Some clergy continue to believe that mental illness is only due to sin or the inability to have faith and will refuse to make referrals (Payne & Hays, 2016; Stanford & Philpott, 2011). It is because of this that mental health professionals need to seek out ways to better understand religion and the role it plays in the lives of their clients (Payne & Hays, 2016; Vermaas, et al, 2017). Unfortunately, both the mental health community and the clergy have not received adequate training to understand how they can help one another (Stanford & Philpott, 2011; Payne & Hays, 2016, p.610). This may be because of differing terminology and past history that have created contrasting value systems of the two disciplines, but either way there might be something that can be done within the rural community that could help with this problem. The current qualitative research of rural pastor's lived experiences with mental health stigma could offer some insight into how to make those changes.

Pastors and Compassion Fatigue

The numbers show that two out of three pastors report involvement with suicidal individuals, and two out of five pastors will spend about 10% of their time performing some type of crisis intervention (Payne, 2014). It is because of these and other traumatic work with their

congregants that clergy are likely to experience compassion fatigue or vicarious trauma, making them ineffective at times when they are unable to get the help they need (Bledsoe, et al, 2013). This situation possibly causes unintended harm to the individual that might be seeking help.

In a study that examined relationships between emotional labor, psychological well-being and job satisfaction in members of the UK clergy, Kinman, and associates (2011) sought to determine satisfaction with the job, as well as opportunities for growth and congruence between the working environment and personal needs. Surveying 180 members of the clergy, there was a wide range of religious denominations with the mean of 25 years within the ministry. Their results showed that there are significant associations between emotional labor and psychological distress that can lead to depression, anxiety, concentration, and memory problems, as well as sleeping issues, thus showing how the clergy are impacted as they work towards fulfilling the emotional demands of their job.

Other results that were discovered within the UK study (Kinman, et al, 2011) suggested that clergy who perform emotional labor more frequently and intensely experienced dissonance between emotions that were genuinely felt. Clergymen, who felt that they were called by God to do the job, reported more psychological distress and less job satisfaction. They also found that although pastoral care is important and rewarding, the perceived lack of support and the demands of the job can possibly create a need for withdrawing from others due to compassion fatigue or vicarious trauma. Consequently, it would be worth investigating whether rural pastors think that mental health training would help with the negative impact of those emotional demands and possibly give them the tools to meet the high expectations from their congregation.

In a meta-analysis that examined vicarious trauma and vicarious posttraumatic growth, researchers discovered that trauma work leads to changes in day-to-day routines that can both be

negative and positive (Cohen & Collens, 2013). The impact of compassion fatigue or vicarious trauma will change one's beliefs, assumptions and expectations of self, others, and the world, thus challenging any existing schemas (Cohen & Collens, 2013). Results from the analysis showed that for there to be growth, the one who is exposed vicariously to the stories of someone else's trauma must also be a witness to their growth.

There is currently a need for more empirical studies to determine what it is that pastors or clergy may find helpful so that they can be better equipped with how to help those in their own congregation as well as how to help themselves with mental health concerns (Payne, 2009 & 2014). This research study aims to fill a part of that gap by looking at how pastors are impacted by their own learned experiences with the mental health stigma of rural community churches and how it may affect the way they help their congregations with those concerns.

Pastors and Adverse Childhood Experiences

According to Anda and associates (2009), the Adverse Childhood Experiences or ACE survey is 10 questions created by Kaiser Permanente in the 1990s to better understand how childhood trauma can impact adults. In their study of 17,337 adults using the ACE survey, it was determined that family members who had experienced any type of ACEs were more likely to have an elevated prevalence for premature death in comparison to those who did not experience any such occurrence. This was a large study, and while it is impossible to say if pastors were among those who participated, it is possible pastors in many areas would not be exempt from experiencing some of the dysfunction explored in the survey and impacting how they might lead their congregations.

The following questions come from the ACEs survey and will only be used as a form of demographic information from each pastor and would be administered before the interview

questions are presented. The answers would be based on the pastors' lives prior to their 18th birthday:

1. Did a parent or other adult in the household often or very often swear at you, insult you, put you down, or humiliate you or act in a way that made you afraid that you might be physically hurt?
2. Did a parent or other adult in the household often or very often push, grab, slap, or throw something at you, or ever hit you so hard that you had marks or were injured?
3. Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way or attempt or actually have oral, anal, or vaginal intercourse with you?
4. Did you often or very often feel that no one in your family loved you or thought you were important or special or your family didn't look out for each other, feel close to each other, or support each other?
5. Did you often or very often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
6. Were your parents ever separated or divorced?
7. Was your mother or stepmother often or very often pushed, grabbed, slapped, or had something thrown at her or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
10. Did a household member go to prison?

A large body of evidence shows a strong relationship between growing up socially disadvantaged and experiencing adverse childhood experiences or ACEs (van Duin, et al, 2018). Long-term effects of ACEs have been known to impact both the psychological and sociological functioning not only in adolescents but also during one's adult life (Wilkins, et al 2017). In connection to pastors or clergy, however, there is little research as to whether ACEs have any impact on the way they lead their congregations or how they determine the best way to help their congregants with mental health needs. More importantly, there is little research of how a pastor's experiences with ACEs could foretell the mental health stigma of their churches.

In one quantitative study, there were 84 missionaries that received the ACE questionnaire and an attachment survey to determine if adverse childhood experiences were having an impact on burnout and their ability to create social connections (Wilkins, et al, 2017). They discovered there was a connection between those with four or more ACEs and post-traumatic stress among the workers who were experiencing burnout. However, it was also found that those with high ACEs tended to have larger groups of intimate friends and family helping them to reduce the attachment anxiety that is usually brought on by childhood trauma.

There are many other studies that have shown a huge link between ACEs and poor adult physical health (Berens, et al, 2020). Pastors in rural areas may be unaware of this connection and do not recognize how mental health and physical health can be linked together. Including the ACE survey could be an eye opener for some pastors who might want to consider using it when they are working with congregants who continue to struggle and make little progress.

Bellis and associates (2014) found those who have a score of 4 or more ACEs are likely to use alcohol and tobacco, become incarcerated, be less educated, have lower wellbeing, and live a less satisfied life. It also has predicted poor quality of one's professional life, low levels of resilience, and even problems with control (Howard, et al, 2015; Herzog & Schmahl, 2018). Pastors may not be aware of how their own ACEs could be impacting their ability to lead their congregations or that their childhood experiences are why they choose not to refer those with mental health concerns. Using ACE questions as a part of the qualitative study could help create a road map for pastors and counselors to better understand where both are coming from.

Chapter Summary

Even though the mental health stigma of society today is not nearly as prevalent as it once was, there is still a stigma within churches that keep many from seeking help. Pastoral leadership could be a predictor of this mental health stigma, and there are some things that may support this belief. First, studies have shown that there is a strong correlation between leadership behaviors and perceived stigma (Britt, Wright & Moore, 2012). Second, it was seen that stigmatizing attitudes towards depressed individuals was higher among supervisors who had more internal need for control, higher levels of stress, ignorance of depression, and less impetus to seek help (Coleman, et al, 2017).

Taking this specific research to the small rural town of Delta Junction, Alaska where there are pastors of different backgrounds will allow for some rich qualitative results that could be useful in understanding pastoral motives. Looking at the lived experiences of these specific pastors based on where they come from, how their lives affect their decisions, and whether they have faced compassion fatigue could also offer perspectives that would help their congregations

and those in professional counseling as well. There is much to learn from this study that could be most useful.

Since community members often prefer to seek out clergy in times of crisis, especially in rural areas (Varmaas, et al, 2017), it is important to have the research that helps us understand what keeps pastors from reaching out to mental health providers. This brings up the current research questions: How might studying the lived experiences of mental health stigma among rural pastors help equip them to work alongside professional mental health workers in the future; what are rural pastors' lived experiences with mental health stigma; how might compassion fatigue impact the way they view mental health stigma in their church; and in what way would adverse childhood experiences impact a rural pastors' view of mental health stigma in their church?

Currently there is a lack of research about pastors as a helping resource in rural communities for mental health care (Hall & Gjesfjeld, 2013). With more research, it would be possible to determine what could be done to make the necessary changes in our rural churches today. In one meta-analysis of five electronic databases from 1980 to 2011, a combination of 144 quantitative and qualitative studies were reviewed to determine the impact of stigma on help seeking within the church (Clement, et al, 2015) and they found that there is a moderate effect on help seeking. Other qualitative studies of pastors and clergies show how their education or religious belief impacted how they counseled their congregation (Payne, 2013). Plus, research has shown the collaborative practices between both pastors and mental health professionals can make a difference (Thomas, 2011).

Chapter Three: Methods

Overview

The purpose of this study was to investigate Alaskan rural pastors' lived experiences with mental health stigma and how their experiences may influence how they help those in their congregations who struggle with mental health concerns. More specifically, this study took place within rural Alaska towns where churches are available for spiritual growth, yet mental health is sometimes overlooked.

This researcher used a phenomenological approach, because the study occurred within the isolated setting of the interior of Alaska, to better understand rural pastors and how their lived experiences with mental health stigma could impact their congregations' mental health. This type of approach was used because there are not many pastors within the interior, nor are there enough pastors for good quantitative research to be done. So, to understand the mental health stigma in this area, it made sense to use a phenomenological approach, since the study was constrained by distance and availability.

This chapter provides a description of how the approach occurred, along with specific research questions, key terms with a discussion of method analysis, the researcher's role in the study, the procedures of verification, and possible ethical considerations.

Qualitative Phenomenological Design

Qualitative research is a method of inquiry that has a long and complex history with roots of sociology and anthropology and helps us understand a specific phenomenon of interest (Heppner, et al, 2016). The intent of qualitative research methods is to make meaning of experiences of those phenomena as they emerge within the context of the research question (Cruz & Tantia, 2016). Qualitative researchers seek to capture one's individual point of view

using multiple strategies such as interviews, data gathering, and observations. There are five types of qualitative research commonly found in counseling research to include ethnography, grounded theory, hermeneutics, phenomenology, and heuristic research (Heppner, et al, 2016; Moustakas, 1994). Additionally, a method known as thematic analysis helps the researcher to identify, analyze, and report patterns or themes within that data (Castleberry & Nolen, 2018).

Phenomenological research is a discovery-oriented qualitative approach that is used to find an exhaustive description of one's lived experiences (Heppner, et al, 2016). According to Max Van Manen (2007), phenomenology is considered to be a project of sober reflection upon the lives of human existence in such a way that it is free from theoretical, prejudicial, and suppositional beliefs, while at the same time driven by a fascination of wonder and meaning about those being interviewed. The goal for the interviewer was to focus on the understandable meaning of the interviewees as they experience different actions, attitudes, relations, and other human matters that tie into the phenomenological design of the project (Lindseth & Norberg, 2004).

This researcher chose to use qualitative processes for this study because there were few pastors available for the study. Being in such a rural area of less than 1,000 people and having approximately 20 churches to choose from made it difficult to find enough subjects for the quantitative study. Also, the pastors who were available were limited by certain criteria, such as being from a protestant church or having at least 10 people in their congregation. Since the essence of this study was to obtain exhaustive understanding of the rural pastors' lived experiences with mental health stigma, using qualitative, phenomenological research allowed for extensive interviews.

While there are multiple approaches to phenomenological research, many rely upon certain guidelines that inform their work. This study used the following steps adapted by Moustakas (1994):

1. Look for a topic with autobiographical meanings and values.
2. Complete a comprehensive review of the necessary literature.
3. Create a criterion by which to locate co-researchers.
4. Find and employ those researchers for the study.
5. Develop questions that will guide the interview process.
6. Conduct and report an in-person interview that focuses on the topic.
7. Organize and analyze the completed interviews.

As the only researcher for this study, steps 3 and 4 were not necessary, as there were no co-researchers.

Research Questions

Q1- What are rural pastors' lived experiences with mental health stigma and what might that look like in their own lives as a leader of their church?

Q2- How might a rural pastor's lived experiences with mental health stigma influence the way they currently help their congregation's mental health needs?

Q3- How might a rural pastor's lived experiences with compassion fatigue be impacting their view of mental health stigma?

Participants

For participant selection, snowball sampling was incorporated by the researcher because of the difficulty of finding participants in hard-to-reach populations for this study (Goodman, 2011). This is due to pastors living in isolated areas where they did not have the necessary

means by which to be contacted, or the ability to contact them was spotty because communication towers are not located close to where they live. Snowball sampling is a procedure used to help researchers access informants or participants through contact information provided by other participants (Noy, 2008). This is done by a snowball effect in which the study gains traction as one pastor tells another pastor that research is being done. Then each was encouraged to participate, starting with the researcher's own pastor, either by contacting those suggested or having the pastor reach out to those he/she thinks may be interested.

Through this type of sampling, the goal was to acquire rural pastors within the Deltana area of Alaska that would be narrowed down based on specific criteria listed below. The pastors were contacted originally by email to explain the study (Appendix A) and then a follow-up phone call was made to ensure that the email was received and to determine interest (Appendix B). Once they were contacted by phone, they were asked if they would like to participate, and if so, were invited to answer a few questions to see if they meet the criteria for the study. The script for this phone call can be found in Appendix C. After a few questions, the pastor was chosen based on the following criteria:

Criterion I. The pastors must have parishioners that have experienced mental health issues in their church (Heppner, et al, 2016).

Criterion II. The pastors must be able to articulate their lived experiences well (Heppner, et al, 2016).

Criterion III. The church that the pastor leads was a protestant church.

Criterion IV. The pastor has a congregation of 10 or more people within the rural confines of the Delta Junction, Alaska area.

Procedures

In the Procedures section, the steps necessary to conduct the study are outlined. This includes, but is not limited to, information about securing Institutional Review Board (IRB) approval, eliciting participants for the study, gathering the data, and recording procedures. This includes taking the written data and applying it to the CMT map as well as eliciting more information from the participants as they laid out their notes and discussed the purpose of their completed map. Once the interview was complete, the researcher took the information gathered by the participants and created a picture that explains in detail the lived experiences of each pastor.

The Researcher's Role

In phenomenological design, the researcher's role is to constantly focus on relations between different parts of the situation as well as the psychological process that may attempt to gain explicit knowledge of how each participant contributes to the collection of information as a whole (Wertz, 2005). It is important that researchers determine which type of technique they choose to follow when conducting analysis; otherwise, there will be little consistency and a whole lot of chaos (Heppner, et al, 2016). For this study, the researcher conducted an in-depth interview with pastors on how they were impacted by their own experiences with mental health stigma of rural community churches and how it impacted the way they help their congregations with those concerns. Each interview followed a prescribed method to ensure that the qualitative data of the participants was derived from the same format.

The researcher conducted face-to-face interviews using conceptual mapping tasks, or CMT (Wilson, et al, 2016), as a qualitative tool to discuss their lived experiences at a time and location that was conducive for each pastor. It is said that the key subject matter studied by

phenomenological researchers is the lived world of human beings, or rather as the "world manifests itself is socially shared and experienced by individuals through their own perspectives" (Wertz, 2005, p. 169). This means that the research questions for this current study were created to capture the essence of each pastor's experience within the phenomenon of their lived experiences with mental health stigma (Heppner, et al, 2016).

Data Collection

Once the study began, the researcher used a single in-depth interview for each participant to assist with data collection. The in-depth interview of open-ended questions is generally used in phenomenological studies to capture the essence of each pastors' experience (Heppner, et al, 2016). Once demographics and ACE information was collected, the researcher moved on to the definition of mental health and mental health stigma so that the participant could share their life story as the researcher took notes. When that was completed, this information was then used to create the conceptual mapping task (CMT) (Impellezzi, et al, 2017).

Conceptual Mapping Task.

The conceptual mapping task (CMT) is a qualitative, phenomenological research tool that is meant to assist researchers in visualizing the nature of a concept and getting to the essence of a person's lived experience while allowing for a more visual representation of an idea to eventually develop (Leitch-Alford, 2006; Wilson, et al, 2016, Impellizeri, et al, 2017). A concept map can also uncover the complexities and nuances that show themselves throughout the research process, making it possible for the developer to be more mindful of what the interviewees have to offer. When concept maps were first created, it was originally meant to understand changes in children's knowledge of science, but today those concepts are used from figuring out a research topic to mapping out a dissertation thesis (Wilson, et al, 2016).

In one study by Martin, et al (1989) CMT was used to determine the conceptualizations of 12 novice and 11 experienced counselors. What the authors found was that using such abstract or deep level conceptualization enabled the experienced counselors to quickly recognize the essential surface elements in each problem, while those who were more novice required additional concepts to conceptualize their clients. CMT was able to help the researchers and the counselors understand the differences of the counselors' conceptualization processes as well as the effectiveness of the counseling interventions based on those conceptualizations (Martin, et al, 1989). This is the goal of using CMT for the current study, so that the researcher may be able to determine a more abstract and deeper level of conceptualization within the essence of each pastor's lived experiences.

Other reasons to use the CMT in this study was to generate rich qualitative data, and to have one interview rather than multiple ones of the same participant. This allowed for easier access to the participant, and it offered built-in member checking features that other types of phenomenological research do not (Impellizzeri, et al, 2017). In other words, the CMT ensures that the participant does not need to return for additional questioning or to participate in a focus group, because it offers follow-up questions within the interview rather than afterwards.

Interviews

The CMT is a semi-structured interviewing procedure that includes four distinct parts. This section will describe the first three parts: Part I. The screening instrument; Part II. The initial interview; Part III. The CMT interview (Impellizzeri, et al, 2017). The fourth part, the processing of the CMT (Impellizzeri, et al, 2017), will be discussed in the Data Analysis Section later in this chapter. The first three parts are described below.

Part I: The Screening Instrument. Once the researcher determined who a potential participant was and contacted those who answered the invitation email (See Appendix A), then a 15-20-minute phone call took place to screen the pastors. During the phone interview (Appendix B) the researcher asked specific questions to see if criteria were met. If the interviewee also answered the following questions, it would show the researcher that the individual was capable of reflection and providing sufficient qualitative data for the study (Heppner, et al, 2016).

1. If you could spend an hour with anyone in the world, either in history or in the present, whom would you choose?
2. I am interested in your choice of the person you chose. Please talk about the individual and what inspires you to spend time with him or her (King, 2013).

Using these questions helped the researcher determine if the nominee fit the role of a participant for the study, because it showed they were able to participate with more than one-word or simplistic answers. Once this was established, then he/she was invited to attend a face-to-face meeting to continue the research. The details of the screening interview were given in script form found in Appendix B. It should be noted that out of the five pastors that were interviewed in this initial phone interview, all five qualified and agreed to participate in the study.

Part II: The Initial Interview Instrument. Prior to the in-depth meeting, the researcher sent out an email to each of the pastors approximately one week prior to the study to remind them of the date, time, and location of the interview. That email can be found in Appendix C.

During the initial part of the face-to-face interview, the researcher followed the Full Interview Protocol. Please refer to Appendix D for the specifics of this interview. Highlights of the interview protocol are in the description below.

To begin with, the researcher built rapport with the participant by thanking him or her for agreeing to contribute to the study (Appendix D) and by obtaining a consent recording of the interview. The consent to record the interview is found in Appendix E. Once consent was signed, the researcher asked the interviewee to complete the ACE's survey for demographic information only. Once those items were completed and there were no other questions, the researcher turned on the required audio recording and continued to the next phase of the interview.

The researcher then gave the participant a copy of the definition of mental health and mental health stigma: "The first definition that I want to give you is from the World Health Organization." The participant was handed a 3x5 card with the following information on it:

> According to the World Health Organization (2019) Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life and can contribute to his or her community.

"The second definition that I want to give you is from the Mayo Clinic". Then I handed the participant the second index card to read:

> According to the Mayo Clinic (Sparks, 2020) stigma is "when someone views a person in a negative way because they have a distinguishing characteristic or personal trait that is thought to be, or actually is, a disadvantage (a negative stereotype)." When those negative attitudes and beliefs are directed towards someone with a mental health condition it is considered to be stigmatizing.

Following this, each pastor was asked to reflect on the following question: *"For the next 15-20 minutes, I would like you to reflect on the concepts of mental health and mental health stigma, and then I would like you to share with me your lived experiences of these ideas both*

personally and professionally in the churches you have served." The researcher then paused and then repeated the statement again slowly, so that the pastor/participant could understand what the researcher was asking. The researcher then asked the pastor to elaborate on their unique lived experiences with mental health.

During this time of recall, the researcher began recording key ideas and concepts from what the pastor was describing on small rectangular (1-⅞"x 2-⅞") Post-it notes®, using one concept per note. Once the pastor or clergy member completed their story, the researcher showed the notes to the participant for member checking to allow time for reflection and corrections or additions (Impellizzeri, et al, 2017). This also ensured that the pastor would not be required to return for further questioning or add any extra steps later for the researcher when it came time to analyze the data.

Part III: The Conceptual Mapping Task. Once all these key concepts and ideas were recorded upon the Post-it notes® and were reviewed by each pastor, the participant completed the following four steps:

1. Each participant was asked to organize the Post-it notes® into a conceptual map on a large piece of paper that visually represented their lived experiences of mental health stigma in their personal and professional lives (Impellizzeri, et al, 2017; Martin, et al, 1989).
2. Each participant was asked to draw a geometric figure around each cluster of concepts that were closely related to each other. They were allowed clusters inside of larger, more complex concepts as well (Reyes, 2020).
3. Each participant was then asked to label those clusters of concepts with a word or phrase (King, 2013).

4. Each participant was asked to draw lines that connect the clusters of concepts that are related to each other and then use arrows in order to indicate directional flow between each of the concepts (Martin, et al, 1989).

In all steps of phase three, the participants were encouraged to modify their maps as needed to correspond with their lived experiences. Then the following questions were used to enlist deeper thought into the topic:

1. Now that you have created this conceptual map about your lived experiences with mental health care, I want you to reflect upon the definition of mental health stigma.
2. As you look at your conceptual map, what strikes you about mental health stigma and mental health care in the Church?
3. Is there anything else you feel compelled to say about this subject as you study your map?

The interview was concluded with the following:

> *Thank you very much for sharing your experiences with me and I am quite grateful for the time you have put forth to help me with this project. As mentioned before, this interview has been recorded and I would like to remind you that the recording and conceptual map will be described in such a way that your anonymity will be protected. If there comes a time that you have concerns about your confidentiality regarding either, feel free to contact me to discuss those concerns and take further steps to ensure anonymity. Thank you again for participating in this study and for sharing your experiences with me.*

At the conclusion, the interviewer used clear tape to fasten the Post-it notes® to ensure that those notes stay on the conceptual map and keep their integrity for further study and reflection (Impellizzeri, et al, 2017). Then once the interview was completed the interviewer followed up with a thank you letter and further communication regarding confidentiality of the audio recording and conceptual map. The Sample Letter to Participant After Face-to-Face Interview is found in Appendix F.

Surveys/Questionnaires

As mentioned in the previous section, the CMT protocol involves a four-part process that includes asking questions, and it then directs participants to create a conceptual map of their experiences (Impellizzeri, et al, 2017). Based on many previous studies, interview scripts and email communications were created for the study (King, 2013; Leitch-Alford, 2006; Impellizzeri, et al, 2017 & Reyes, 2020). See Appendix A-D for further detail of these scripts.

Document Analysis

The following three pieces of information were used to analyze the results of this study. First, each interview was audio recorded, allowing the researcher to go back and analyze the voices of each participant later and analyze any vocal nuance that each participant used. Secondly, each recording was transcribed for the purposes of looking for content that established the development of themes and sub themes. And third, each conceptual map was analyzed for content, and it allowed the researcher to refer to each participant's interview which offered a saturated amount of shared meaning (Impellizzeri, et al, 2017).

Focus Groups

As mentioned in a previous section, because of the built-in member checking feature of the Conceptual Mapping Task, follow-up interviews and focus groups were not necessary to

establish validity (Impellizzeri, et al, 2017). The CMT allowed each participant to be active in creating meaning in the moment, and the very act of member checking in the middle of the CMT established validity. To be more specific, during Phases I and II of the interview, the researcher wrote down one concept for each Post-it note® and stacked them in the order that each participant said them. Then, the researcher gave the participant the notes back in order they were written and was asked to check the notes for accuracy.

Observations

The observations of the CMT include the following three collection methods. First, the researcher was able to make observations in the moment of conducting the CMT by making comments in the audio recording to the participant as a participant field observer (Leitch-Alford, 2006). This established a baseline where the researcher was able to revisit the interview when needed in the data analysis (Leitch-Alford, 2006). The researcher was also able to make field notes at the conclusion of each CMT interview. Second, the researcher was able to transcribe the interview and follow along with written words while revisiting the audio recording. This allowed the researcher to identify themes and subthemes more clearly from each interview (Lindseth & Norberg, 2004). Third, the CMT method of gathering data allowed the researcher to further analyze the concept map as an artifact from the interview, and this was proven valuable to the researcher while she revisited the audio recording and transcript of each participant.

Data Analysis

This section covers *Part IV of the CMT: The Processing of the CMT and Data Analysis* (Impellizzeri, et al, 2017). After each interview was completed, then the recording of each interview was individually transcribed and evaluated for common themes and subthemes (Lindseth & Norberg, 2004). The purpose of the data analysis was to identify and compare ways

in which pastors understand their experiences with mental health stigma as expressed in each interview. Interpretative phenomenological analysis (IPA) provides flexible guidelines and uses the following stages (Shinebourne & Smith, 2011; Smith, et al, 2009):

1. The researcher will begin analysis by reading and rereading the original data presented by the participants.
2. The researcher will make notes by free association and exploring content.
3. The researcher will focus on chunks of different transcripts and make them into themes.
4. The researcher will then search for connections across those themes.
5. The researcher will bracket previous themes and remain open-minded to do justice to the individuality of each participant.
6. The researcher will look for patterns across the cases and take note of their idiosyncratic instances.
7. The researcher will take interpretations to a deeper level by utilizing metaphors and importing other theories as a lens through which to view the analysis.

Moustakas (1984) tells us that in phenomenological studies "the investigator abstains from making suppositions, focuses on a specific topic freshly and naively, constructs a question or problem to guide the study, and derives findings that will provide the basis for further research and reflection" (p 45). This means that the researcher's role is one as an active bystander that involves more than asking questions, but also guides the participants to a place where they can freely share their lived experiences without bias, knowing their voice is being heard and understood.

As noted in the Document Analysis section above, this researcher not only used chunks of different transcripts and made them into themes in point 3, but at the same time, she was also

listening to the audio recordings and viewing the concept map. While listening to transcripts and viewing the CMT of each pastor, the researcher was able to depict three basic themes that came out of the review. The material gathered was then analyzed for similarities and differences between the pastors' lived experiences, and the entire body of data was compared to other literature in the field to fill in any gaps of previous research (Leitch-Alford, 2006).

Trustworthiness

Trustworthiness of any research should promote credibility, dependability, transferability, and the ability to confirm what is being studied. According to Malik (2021), validity or trustworthiness must be represented by both the researcher and the participant. In this study, the trustworthiness was backed by member-checking when the participants were able to review the Post-it notes® used by the researcher during the interview itself. Recording the interview also helped to achieve trustworthiness and was used by the researcher to ensure all quotes were properly cited by each participant. Doing this also helped with meaning making and making sure that the study itself is accurate.

Credibility

Credibility refers to the extent that the researcher is believable, and the results are appropriate for the study's content (Malik, 2021). Credibility helps to establish a level of agreement between the researcher and participant while establishing trustworthiness in the study's findings to determine what is true and what is not. In this case, the CMT provided credibility in the moment of the interview, because each participant checked the researcher's Post-it notes® before creating the concept map (Impellizzeri, et. al, 2017).

Dependability and Confirmability

Dependability was the assurance that the evaluation, interpretations, and recommendations of the different findings are supported (Malyk, 2021). Dependability also refers to how the procedures are followed and documented so that other researchers can find the same conclusions using the same type of protocols, meaning other researchers are able to confirm the results.

Transferability

Transferability occurred when the researcher did her due diligence and described the research context as well as the study's assumptions (Malyk, 2021). This allows for anyone who might also be interested in the same type of study to research in another context yet may find the information from this study useful and reasonable for theirs. In this study, caution should be used in transferring specific findings because this is specifically for Alaskan rural pastors. There may be some transferability in other rural pastoral contexts.

Ethical Considerations

Ethical considerations were taken seriously when determining the best way to avoid any psychological harm towards participants (ACA, 2014). This was done by addressing consent, confidentiality, and making sure that no data was collected until IRB approval was acquired. This IRB approval was obtained from Liberty University on 8-17-2021. The pastors in this study knew from the beginning that their participation was voluntary, and they could choose to stop the interview at any time. Each participant chose a pseudonym for themselves in place of their own name for the study.

Before the study began, each pastor was informed of their right to withdraw without penalty and was also informed that the only person with access to their interviews would be the

researcher. However, if they wanted to have the researcher destroy all notes and recordings, she would grant their request. They were also told that all information was being stored in a locked filing cabinet in a locked room while not being used, and all electronic information was password-protected on the researcher's computer in a locked room.

Summary

This is the description of a qualitative research study that explores how pastors in rural Alaska are facilitating the mental health stigma in their churches. Moving forward with a design to include the ACE survey, compassion fatigue, personal stigma, and conceptual mapping to examine whether a pastor's background impacts how they help their people and whether it is affecting those who are struggling with mental health problems within their congregations. The phenomenological results are an "exhaustive description of the phenomena" (Heppner, et al, 2016, p. 388) and reveal whether their background could have any bearing on the mental health stigma in their own churches. Concept mapping has been shown to provide a unique, participatory data collection design that allows for individual responses and creates a more applicable result based on what the study is looking for (Vaughn, Jacquez & McLinden, 2013). The data will be collected through interviews, mapping concepts, and other questions used for basic demographic information.

In this study, answers were sought to the following questions:

1. What are rural pastors' lived experiences with mental health stigma and what that might look like in their own lives as a leader of their church?
2. How might a rural pastor's lived experiences with mental health stigma influence the way they currently help their congregations' mental health needs?

3. How might rural pastor's lived experiences with compassion fatigue be impacting their view of mental health stigma?

The goal of this study is to fill a research gap that looks at how pastors are impacted by their own lived experiences with the mental health stigma of Alaskan rural community churches and how it affects the way they help their congregations with those concerns.

Chapter Four: Findings

Overview

This chapter represents the results of data analysis found while examining the lived experiences of five rural pastors in Alaska. First, it will introduce the demographics of each pastor, and their ACE's or Adverse Childhood Effects results with a discussion of those results. Secondly, the contextual map of each pastor will be discussed and assessed to determine similarities and differences of each CMT. In the third section of the results, there will be a review of themes that were discovered while interviewing each of the pastors. This will help to solidify emerging ideas that came through each pastor's narrative or story based on phenomenological inquiries. The last section will conclude any other ideas that came up during time of examination.

Demographic Data

To begin with, pastors were chosen based on the following criteria. They needed to be 18 or older, have at least 10 people in their congregation, live in a rural area within 90 miles of Delta Junction and pastor a protestant church. Also, they must be able to fill out an ACE's form and be willing to share their lived experiences with mental health stigma both professionally and personally. All the pastors that were interviewed met this criterion and were, for the most part, willing to share their lived experiences. Some were hesitant at first to share their stories, but with time began to open up and be more forthcoming. However, due to the isolation of the area, it proved difficult to find pastors who were willing to be interviewed for a variety of reasons such as: they were too busy, they felt uncertain, and/or they were just not willing.

It should also be noted that in the responses to adverse childhood effects assessment, only two of the five pastors had marked any ACEs, and at the most was two. ACEs are childhood

events of neglect, abuse, and household dysfunction that are experienced between birth and 17 years of age (Crouch, et, al, 2019). According to Howard et al (2015) those who experience a certain number of adverse childhood effects or ACEs impact a person's worldview and how they perceive events shared or experienced. While the ACE scores were low, all the pastors had experienced a traumatic event at some point in their life that had impacted their choice in becoming a pastor or helped them to be better pastors. This dynamic of the pastors having a very low ACEs score will be further addressed in both chapters 4 and 5.

Participant Profile Experiences

The purpose of this section is to introduce each of the pastors or participants and their profiles. Identifying information was withheld to protect their identity. Each pastor was given an opportunity to create their own pseudonym so that their pastorate would not be recognized. All will be labeled Pastor with a name of their own choosing. Within each of the profiles both contextual and structural descriptions will also be provided along with the results of their CMT.

The descriptions of the interviews are in the order that they took place. The following is a graph of each pastor, their pseudonym, years they have been serving their church in Alaska, how many people usually attend their church, their current age range, and whether there are other pastors who serve with them. Interviews with the pastors occurred between September and December of 2021. Each pastor chose a name that represents who they are and Pastor Buffalo, Pastor Red, Pastor Marie, Pastor Mike, and Pastor Stockton all shared their lived experiences of being a pastor in rural Alaska and how they have been impacted both professionally and personally by mental health stigma.

Pastors	Years of Ministry in Alaska	Church Size	Age	Other Pastors
Pastor Buffalo	15-20	100-150	60-70	No
Pastor Red	30-40	50-100	60-70	Yes
Pastor Marie	5-10	50-100	25-35	Yes
Pastor Mike	20-30	10-50	50-60	No
Pastor Stockton	5-10	10-50	60-70	No

Figure 1

Pastor Buffalo

Pastor Buffalo is a Caucasian, married, male who currently lives in the Delta Junction region and pastors a protestant church with approximately 100 congregants. He has lived in the area over 20 years and been preaching for about 30. He chose to participate with the study out of curiosity, and during the interview he was able to come to some interesting conclusions about mental health and its stigma. He was the first participant and met with the researcher at her office.

Pastor Buffalo spoke of many different situations that involved his own personal and professional experiences with mental health and stigma. He specifically spoke about different types of stigmas that occurred in his teens and again in his twenties. The pastor felt that these experiences have shaped him and helped him to understand mental health stigma.

Adverse Childhood Experiences. Pastor Buffalo looked over the ACEs assessment and asked questions while reading it. He did not feel that he had experienced anything listed on the ACEs questionnaire. In fact, he felt that he had grown up in a well-adjusted environment that taught him about spirituality and gave him moral values that were instilled within him for life. So, there were no ACEs checked for Pastor Buffalo.

Textural description. From the review and analysis of Pastor Buffalo's recording, transcript and CMT the following themes emerged: Introduction to stigma, mental health and relationships, church and mental health problems, and taking care of self. Each of these themes are described in more detail.

***Introduction to stigma*.** Pastor Buffalo shared that he was first introduced to stigma as an adolescent in high school. He came from a family that encouraged Christian values and he chose to follow those ideals. But at school he found that not everyone agreed with him and he was treated differently for those beliefs. This was a continued theme when he went to a secular college for farming. Eventually, after being a sheep farmer he did attend a Bible college and was surprised that this was an issue even then.

> So, coming from a really well-adjusted middle-class family, I did receive some stigma as someone who would not get involved with the drugs, the alcohol, the sex and things at school and was always adamant that I wasn't going to do that. So, I did suffer some stigma which was extremely minor in that form. Some would ask, what is your problem?

> Why can't you use drugs? This carried on into life on the ranch because I still maintained not being sexually involved, even as mid 20-year-old person. Even had people ask if I was gay, which I found to be humorous.

Mental Health and the Church. Pastor Buffalo was first introduced to mental health problems when he became a pastor. Specifically, he came across two women who struggled with accepting their husbands, both of whom were unable or unwilling to take heed to what Pastor Buffalo was telling them.

> There were two particular women through my career both pretty much had very similar issues. Just could never mentally come to the point where they would accept their husbands for who they were. One made a pass at me. Which was interesting. Another one, tried to dominate my time. So finally, I had to tell her, you know, we were not going anywhere. So, I'll refer you to somebody else. So mentally health wise, just mentally not able to accept life and deal with them. One case for two years and the other one for two years. Just never came to the point where they could just accept life as it was and I think both of them wound up getting divorced.

During his first year as an assistant pastor, he was introduced to mental health problems that began to shape his experiences. He shared that one of the first calls to help someone included a person who was out of control and seemed demon possessed. He recounted:

> I had been out of Bible college for less than a year working with a pastor, and we got a call that a man needed help. So, we went to the place and the man was obviously from the moment going in was mentally disturbed, biblically speaking you would look at his circumstances and you would question about being demonically inspired, if I could put it that way. As we came in, the angrier he got, the more we tried to talk to him. The more

> we tried to talk to him the angrier he got. He was an elderly man. Probably alcoholic, from what was learned. Very frail, very skinny. But when he came at us in a rage of anger, he was very powerful, ripped the shirt right off of me.

At that point, the pastors had introduced this demon-possessed man to Jesus and planned to come back the next day, only that did not happen because he had disappeared and was never seen again.

Taking Care of Self. Pastor Buffalo at some point in his career realized that he had reached his limit, and through teaching and wise counsel of other pastors, he had been aware of triggers and what he needed to do. So, the pastor would cancel appointments and take a day off or two so he could recharge. He shared,

> What led up to just people being people. More me than people just reaching my limit. But fortunately, through teaching and wise counsel from other experienced pastors, I knew some of the triggers of what to do. So, I withdrew. In other words, I mean, throughout my ministry career, cancel appointments, if needed, take a day off or few hours off. But I think that the big thing would be to recognize the trigger before it overcomes you and you find a way to overcome it.

Conceptual mapping task results. After Pastor Buffalo listened for the directions of creating his conceptual map, he then carefully took the proofed Post-it notes® to create his own version of life experiences with mental health stigma both professionally and personally. While mapping out those notes, he came up with different themes throughout his life. These included the formative years, the challenging years, committed to values, life changes, learning ministry, and working in the ministry.

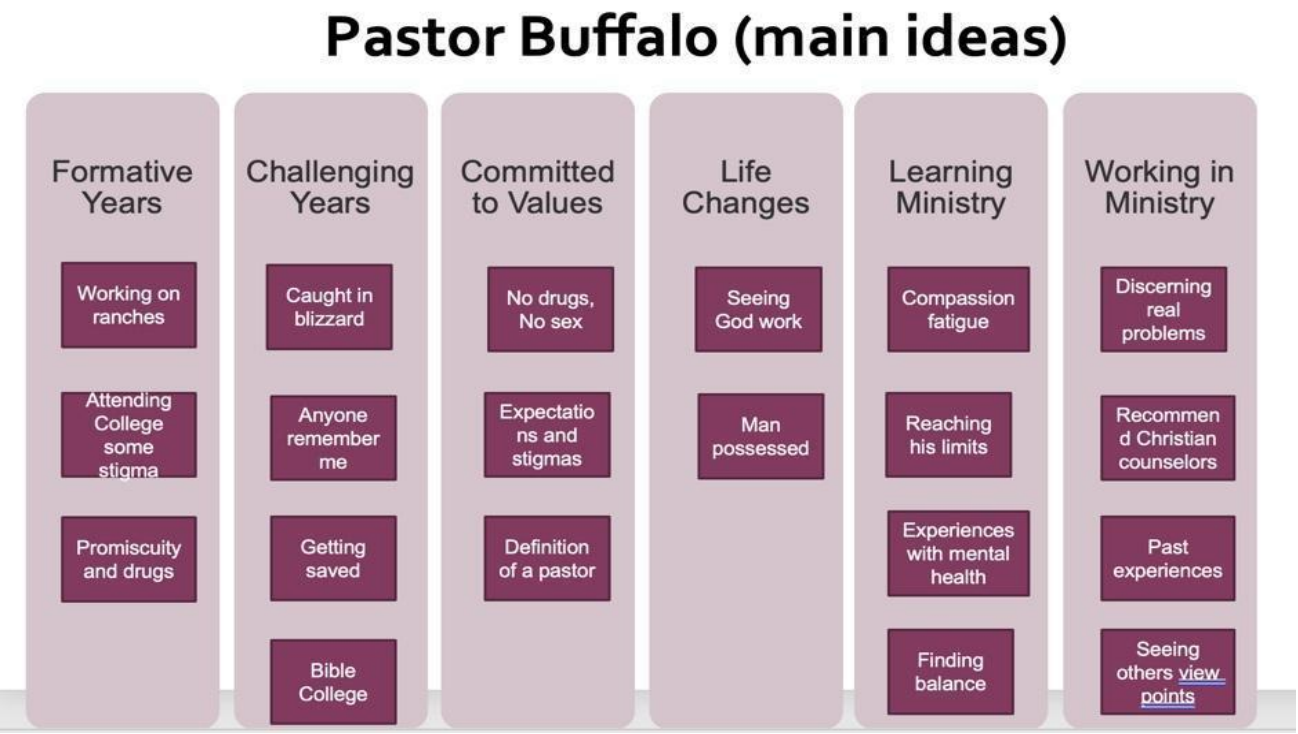

Figure 2: Pastor Buffalo's Conceptual Mapping Task

Formative years. The first one referred to the "formative years" where he originally encountered stigma because of his belief system, which was passed down to him by his family. While he did not grasp at that point what it meant to live for Christ wholeheartedly, he did recognize the need for morals and standing by what he believes.

Challenging years. Next on his CMT was the "challenging years," when he experienced a brush with death that catapulted him to a realization that he really did not know what life was about. This life changing event, a blizzard, had him asking questions that he had not thought of before like "what is important" and "if I die." These questions are what led to a life course change, and after 8 years as a farmer he eventually was called to the ministry as a pastor. This was never something he planned for or expected, considering that all he wanted to do was work on a farm in some capacity. After all, he preferred "animals over people anytime."

Committed to values. Then on the map he titled the next section as "committed to values." This is when he went back to college to become a pastor, and even though he was thinking about dating and marriage, he continued to stick with his morals and beliefs. For some this was hard to understand, even at Bible College. Because of this, he experienced stigma here as well and realized that this was based on cultural norms, but this did not mean that he needed to do what everyone else was doing. This is a continued theme for him as he lives his life and makes decisions that impact his daily spiritual walk with God.

Life changes. Another theme that was written on the CMT involved "life changes." His very first year as a pastor associate, he was exposed to mental illness that he felt was more about demonic possession. He and the lead pastor answered a call to meet with someone that was highly unstable, volatile, and acting out in a rage. Pastor Buffalo saw first-hand what this looks like and he shared the following about that experience:

> I had been out of Bible college for less than a year working with a pastor, and we got a call that a man needed help. So, we went to the place and the man was obviously from the moment going in was mentally disturbed, biblically speaking you would look at his circumstances and you would question about being demonically inspired, if I could put it that way. As we came in, the angrier he got, the more we tried to talk to him. The more we tried to talk to him the angrier he got. He was an elderly man. Probably an alcoholic, from what was learned. Very frail, very skinny. But when he came at us in a rage of anger, he was very powerful, ripped the shirt right off me.

Learning ministry. From there he titled the next section as "learning ministry." This theme described his experiences with compassion fatigue and what he did to combat this problem that plagues many pastors. He shared that for him compassion fatigue was:

> What led up to just people being people, more me than people just reaching my limit. But fortunately, through teaching and wise counsel from other experienced pastors, I knew some of the triggers of what to do. So, I withdrew. In other words, I mean throughout ministry career, canceled appointments, if needed, take a day off or a few hours off. But I think the big thing would be recognizing the trigger before it overcomes you and you find a way to overcome it.

Pastor Buffalo learned to withdraw and take time for himself so that he could be refreshed and ready to do God's work. He said that much of what he learned came from others in the ministry and paying attention to their counsel. Being willing to stop and take a breather when he noticed that he was struggling with people.

Working in ministry. Another title for his CMT was "working in ministry" and this is what he referred to as a time that he learned how to discern the "real problem" between spiritual and mental health concerns. Pastor Buffalo said he finds that there are two things that he has seen in his congregation that he has learned to discern what the issue is. First it can be a result of their own past experiences that is absolutely none of their fault while for others it is due to the choices that they have made that has gotten them to this point. He shares that the best way

> …to discern the problem or to try and help the first thing is to discern what the real problem is. What do I find? I find that sometimes it can be a result of past experiences

> that it is absolutely none of their fault but have affected them to where they are. Sometimes it is the choices that they have made, that has gotten them to this point. I would say that is the two most common.

While Pastor Buffalo has not seen a mental health counselor for himself, he has realized at some point in his career as a pastor that he is not going to be able to help everyone. It is his experiences with his congregation that led him to this conclusion and even today will refer church members to a Christian mental health counselor if he can.

Other viewpoints. In Pastor Buffalo's final section on his CMT he wrote "other viewpoints." This referred to his experiences with non-Christian counselors and some that even believed Christianity has "no basis with which to help others" in this capacity. He shared that there was a family friend who worked as a psychiatrist, and this was much of his basis for the counseling community for quite a while making it difficult for him to want to make referrals believing most counselors did not think Christianity was important or necessary. But over time he has come to see that this is not true for all counselors. In reference to this Pastor Buffalo noted that:

> Of course, from my standpoint, I would almost always recommend some type of Christian based counseling. If I knew a secular counselor, really well, it's a possibility. We do have a family friend, who is well respected, a long-term mental health professional in the state of Alaska. We have had some very interesting discussions through the years about how Christianity has no basis.

Interview conclusion. Pastor Buffalo shared in the interview that one of the most important things that he has learned from his experiences as a pastor is that it has helped him to know himself and how he can be confident, and mentally healthy so he is able to help others who

are struggling in whatever capacity he can. He also felt that these experiences with stigma taught him

> …that my values were my values and I needed to stick with them regardless of what other people thought of my values. I can learn from my experiences, so I can know myself, and know how I can be confident and be mentally healthy in a position to be able to help other people.

Pastor Red

Pastor Red is one of four pastors within a Pentecostal church in Delta Junction. Pastor Red is an African American female who currently ministers to the children of her church and preaches as needed during church services. Being in her 60s, she has seen and experienced many things. She has been married over 50 years and has two grown children, and three grandchildren.

Adverse Childhood Experiences. Pastor Red spent a few minutes reading over the ACEs questionnaire and shared that she did not have any experiences that related to this assessment. In fact, she remarked how thankful she was that she had not experienced anything that was listed under the ten statements. She also shared most emphatically that although they grew up with some disadvantages, they had everything they needed when it was needed.

Textural Description. When working with Pastor Red it was clear that there were many different topics for her when it came to discussing childhood and adult experiences with mental health and mental health stigma. Eventually these topics became some of the main themes that came out of her interview. These included childhood experiences with mental health, becoming a pastor, and understanding how people work.

Childhood experiences. Pastor Red shared that her first experiences with mental health and stigma were during her time with her younger brother, George*. She was the 6th child of 7 and George was the 7th. George was mentally disabled, or as she referred to him as mentally ill. For her family, George was just as important and loved as anyone else. There were no differences, and he was not treated any differently than other family members. She said that when George was born, the "state" had tried to take him from her mom, but her mother believed that if God gave him to her then "there was a reason for it."

Pastor Red believes that it was this experience with her younger brother that made her more sensitive to others that may struggle with mental health issues. She reflected that even now she realizes how her childhood experiences with her brother helps her to be mindful of how others should be treated when they are having trouble with a mental health problem. When asked about those experiences with her little brother she said

> … my younger brother, next to me, which he is passed away. He was mentally ill. And we never treated him differently. So, all the while we grew up here and I was saying but we were really close. He had like an extraordinary ability to play piano and had never touched a piano before. First time he tested a piano he could just play it and he loves to sing, and they tried to take him away from my mom, when he was little because that is what the state used to do back then and put him in a mental home and my mom said no, she said that if God gave him to me it was for some reason.

Becoming a Pastor. During Pastor Red's time as a pastor, she shared that there was one individual that also had problems like her brother and her childhood experiences helped her to work with this person without judgment but rather with love and acceptance. Because of this, anytime there were others that struggled with a mental illness they would be referred to Pastor

Red for counsel as a safe place to talk. It has been her desire to help as many as she can in a way that is uplifting and encouraging to those who struggle. Pastor Red continues in her own words

> …it's just because I have experience with my brother. So, I pick up on that, on that need for them all, all the pastor's love. All they really ask for is love and they don't know how to ask for love but that's what they see and when someone instructs them in a particular situation, they will associate that love…

Understanding others. Pastor Red shared that she has worked with many who struggle with depression and anxiety. From those individuals she has learned what to say and what not to say. Many times, she would witness how they would give in to the stresses of life and realized that they just needed someone to talk to. So, she will get many calls because people have learned that she is safe and a great listener. She has noticed that many believe that their problem is big, and she finds that if she acts like it is big too, she can meet them where they are. Pastor Red explains in detail:

> We have had people like that in the church and you try to pull them out of it as much as you can. You can always tell when they go into a state of depression, it shows on their face. More than anything, you want to help, so then you kind of regroup. You are going to talk to her and talk to him in a different state that builds them up instead of putting them down, you know, not like you were gonna pull them down but some things you can't say to them because you say anything to them, they will automatically be stressed so you have to take everything into consideration when you are talking to them. You do have to pray as you are talking to them so that you can be in the right frame of mind.

Conceptual Mapping Task. Once Pastor Red was given her instructions and had reviewed the Post-it notes® that were written out for her, she was able to take the notes and place them on the poster board in the order she saw fit. As she went through the pile and then grouped the concepts together, she came up with the following themes: My brother, best friends, car accident, rebuilding a person, finding myself, and training in life.

Pastor Red's CMT

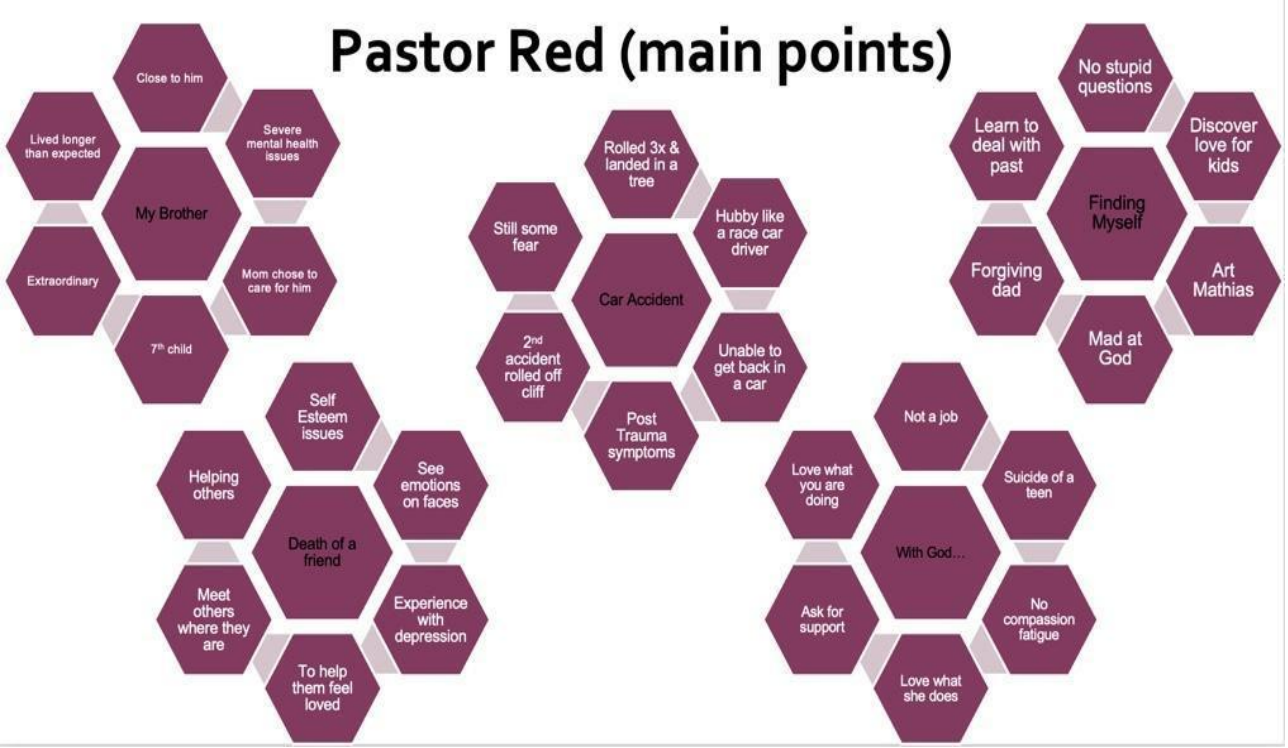

Figure 3: Pastor Red's Conceptual Mapping Task

My brother. Pastor Red learned that love could cover many things, and this came from living with her brother. He had a mental health illness, plus he aged rapidly, so even though he was an adult he still was about 30 years behind. When he died at around 60 years old, he was emotionally and mentally only 30. But she is thankful for those experiences with him. She saw him as her best friend and learned that individuals like this just want to be loved like everyone

else. This strengthened her to love unconditionally not only her brother but others that experience similar problems. In her own words:

> … he was extraordinary. He was my best friend before he died. I was away and my mom called me on the phone, and I talked to him for about 10 minutes… and when he died, he got really sick and they said that physically there was nothing wrong with him, but he aged really fast and they couldn't stop whatever was going on. He just slid off of his bed onto his knees and he was gone.

Best friends. Another experience that shaped her life was when she met someone in her church that struggled with anxiety. This person was hard to understand and tended to alienate others. But she wanted to understand and was able to see the problem for what it was. That it was more about self-esteem and how that person viewed herself. She found that through compassion she was able to get through to this person and over time they became fast friends. In the end, when her friend became very sick, it was hard for her to see her like this. This too was a part of being strong and understanding how to meet others where they are.

Car accident. Pastor Red went into detail about two of the traumatic experiences she had in vehicles. Both times she was with her husband, and with each incident she realizes that God was with her but it did not make it any easier after they happened. At some point she started to struggle with even getting in a car when someone else was driving making it really difficult not to panic. She shared her story

> All my life I have never before been scared of being in a car, my husband drove like a racecar driver and we both came from Detroit. One day it's icy snow, like Alaska and suddenly my car rolled three times and ended up in a tree. I didn't know what was wrong with me after that because I could not get in a car and I would just be gripping things and

> the driver would not even be close to the edge but it looked close. Then it happened again and my spouse went off the edge of a cliff and that did not help any. I was not hurt or anything and I know that was the Lord, but I realized that it was trauma from those accidents.

From this experience she recognized how others would be impacted by trauma and that anyone can go through something like this and even if saved will have post trauma reactions that can keep you stuck. Pastor Red said, "I've come to the place where I have walked away from that trauma, but I still feel like it a little here. This has required me to pray for peace when in a car no matter who I am with."

Rebuilding a person. When we talked about compassion fatigue, Pastor Red said that she had not experienced this phenomenon. But she spoke about watching someone else go through this process. When the other pastor was showing signs of being overwhelmed and struggling to make sense of those who needed her. Pastor Red encouraged her pastor colleague to take a sabbatical and give herself a chance to regroup. Eventually she came back and was in a better space. But even now Pastor Red sees how people can suck you dry if you let them. She shares her experience:

> …she did nothing wrong. It's just that the passion was overwhelming her and I said, you know, we all get overwhelmed and He said to be healed not only from this but from the stuff that has happened to you. So, she took a sabbatical and stepped down as the lead pastor and became just an elder of the church. When she came back after a year and half, she seemed to be in a better place but every once in a while, you can tell she is still holding on to it.

Finding myself. When I asked Pastor Red about how she has avoided compassion fatigue she attributed it to working with children and how they do not put on any façade. Children are the first to tell if there is something wrong, and "they can pull you out of yourself." They also love people for who they are, and she feels she can relate on many levels with the children she works with. It has taught her patience and even more compassion. All of which she learned from her relationship with her brother.

Training in life. Pastor Red shared that she has never worked with a mental health counselor, but she did take a class from someone that trained pastors about mental health. When she attended the class, she did not believe that she had any problems. But as time went on, she found that she was struggling with the death of her dad. From that experience, she had an opportunity to work through her father's death. She said,

> I learned from this teaching that I was holding on to my father's death, angry with God, but I had no idea. I was mad at dad, and I was mad at God. The trainer told me to pretend that he was her dad you can use me as your father, what would you say to your father if he was alive, and I shared things that I never told anyone and did not know was even there. He also told me that if every time you think about this it brings you down then you haven't dealt with it but when you can talk about it to somebody you should feel good in your body. I felt really clean after that.

From this experience she learned that she could lean on others to help her work through some tough events in her own life. This also helped her to see the importance of referring others to counseling.

Interview Conclusion. At the end of the interview Pastor Red discussed some of the nuggets she has discovered while working in the ministry. She said, "with God's help all things

are possible." She then referred to the death of an 18-year-old that she knew very well. He had taken his own life over the loss of a relationship. She found it difficult to process and understand why someone would take their own life over something like this. But it has taught her that hardships like that are difficult, and everyone works through them in different ways and without God, there is little hope for those that depend only on people.

Pastor Marie

Pastor Marie is married and a Seventh Day Adventist pastor that has been assigned a huge territory to cover with her spouse. She works with different small congregations within the interior of Alaska such as North Pole, Delta Junction, as well as Barrow (Utqiagvik) which is the most northern community within the United States with about 4,300 people. Even though she has only been a pastor for about four years, she has had many experiences that have helped to shape her and encourage her to continue the work that God has called her to accomplish.

Adverse Childhood Experiences. Pastor Marie did not check anything on her ACEs assessment. However, she did remark that there were traumatic events but they did not pertain to the statements on the form. Mostly what she had experienced had to do with abandonment from certain family members and friends that she believed had her best interest at heart. This included the death of a new friend about 17 or 18. She felt that it was these things that impacted her early years, but also were situations that helped her to grow and understand others who also had been through similar hardships.

Textural Description. During her interview the following main themes emerged: Being called to ministry, dealing with hardship, and learning about mental health through her congregation. Other concepts included: professional experiences, personal experiences with trauma, and personal counseling experiences.

Being called to the ministry. When Pastor Marie was about 16, she felt that God was calling her to be a pastor and this belief was solidified when she began working for a Seventh Day Adventist call center and was eventually promoted to the job of Chaplain. She did this for about 4 and half years as she worked her way through college to become a pastor. During this time, she worked with many individuals who called in for different problems. She explains the following:

> …in a job I had, I worked with a lot of people that just had a lot of baggage in their life and I grew more compassion I think for it through listening to their stories and just being there with them in their moments of struggling. So those were defining moments for me and then they helped me to appreciate that battle that they are facing and also that they are incredible individuals you know just because they did. They had a trauma that has affected them, or they had a mental health issue that was maybe more, more chronic for them that wasn't related necessarily to the trauma that they could think of, you know like the anxiety in cases like that. I think it made me more aware of… how mental health can affect people's way of functioning in the world, and where they may need additional help.

This also included those who dealt with different conditions such as an illness, depression, anxiety, grief, and other mental health issues. She felt that many of her experiences were a training ground which would eventually give her the ability to help her congregation today.

Dealing with hardship. As Pastor Marie shared her difficult life experiences, she mentioned that within the first two years of college her roommate died in her sleep. This was very difficult for Pastor Marie to process because she felt this person was going to be a lifelong friend since they had gotten along so well. And after having friends that had betrayed her, she

thought that this was something she could count on. But it did not work out that way and she was caught off guard and once again, felt abandoned. It would eventually make her uneasy about friendships and unable to trust others or believe that it would last. This would have been a pivotal point in her ministry as she moved forward to do God's work but leaving her with more questions than answers. Pastor Marie shares:

> I lost my roommate when I was 17, I think, maybe I was already 18. At this point, but um, yeah, my roommate in college, she died in her sleep, actually. And that was pretty traumatizing for me… I think it made me understand grief better. I have lost people in my life, friends, and family but that one was really close to home. She was about my age, and this is your… this is my roommate, and we are friends. And I had hoped that we would be friends for life because we had really connected. But yeah, so that was very defining for me I think when I look back.

Learning about mental health through a congregation. Today, Pastor Marie has many different stories that reflect her experiences with mental health and mental health stigma. She specifically shared about one particular congregant that she related to due to her own life experiences. She shares her story:

> This was kind of a complex, but neat story… There was this person had a strong inferiority complex and it had been rooted in them over time. This was because of what they had been through and how they began to see people in such a way that it colored their reality negatively. And so, working with this individual I felt I could help them because I had dealt and worked through an inferiority complex earlier in the ministry and as a teenager. So, I understood where he was coming from, and it was very interesting to walk with them through that and watch their growth.

She felt that it was her own inferiority complex that gave her the patience and compassion to help this person in a way that was respectful and truthful. Eventually, this person was able to see his world differently and move out of this belief system. It was specific situations like this that make her thankful for her own traumatic life experiences.

Conceptual Mapping Task. Once Pastor Marie received the instructions that enabled her to create the CMT she took the Post-it notes® and began creating what she believed described her own life experiences with mental health and mental health stigma. The following are the topics of discussion that came from Pastor Marie's CMT assignment: Defining life development/experiences, childhood experiences, learning and growth, and personal mental health situations.

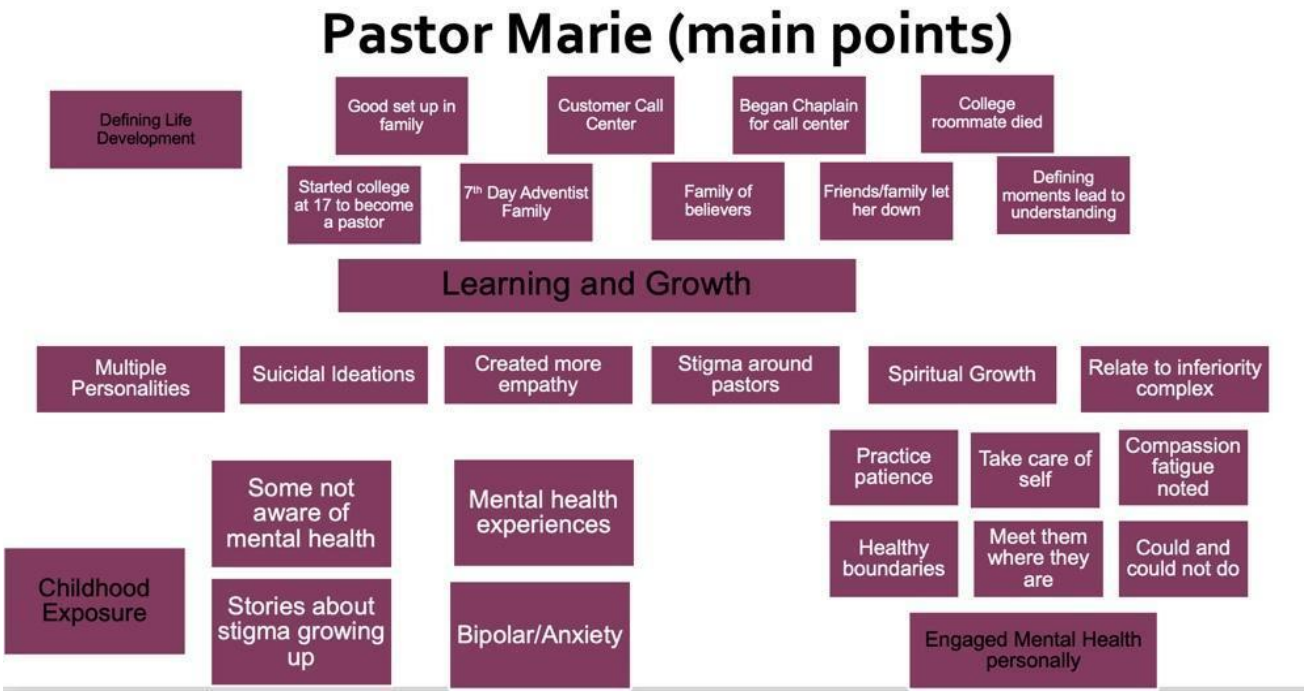

Figure 4: Pastor Marie's Conceptual Mapping Task

Defining life development/experiences. In this section Pastor Marie placed the Post-it notes® that dealt with her college and work experiences. Other notes in this section involved her nuclear family and how this time of her life was pretty stable. This was also the time that her

brother had married a woman that she became very close to. But eventually her sister-in-law and brother got divorced, and then this woman just vanished with her niece never to be heard from again. She was unable to understand the purpose for this and was very hurt by the outcome. She explains:

> … When I got to the beginning of college actually, she (sister-in-law) divorced my brother, and then took my niece and completely cut off everyone in the family. And so, it was kind of pretty quick switch she went from, you know, learning on us, you know, and talking about how much she loved us and cared for us to all of a sudden, completely cutting us out in every way and cutting off any connection with my niece and so that was pretty dramatic, that was pretty traumatic for me because I was very close to that situation. And so that was a pretty deep wound that I had to work through the process. So those are, I'd say some of the more defining (experiences).

Childhood exposure. The notes under this topic focused on her early years with family and friends. She noted that even though there may have been some stigma around different mental health conditions during this time she felt that her family was supportive and even though there might have been some anxiety it was not incapacitating for her because of this support. She stated, "there was some experience with bipolar who dealt with depression in an unhealthy way and did not understand their condition". She found that those who did understand their conditions were able to cope well and it was "helpful for her to see that."

Pastor Marie also shared her childhood experiences with trauma which is when feelings of abandonment began and she felt betrayed by those she thought were her friends. She spoke:

> I didn't ever experience abandonment or betrayal from family, but I did experience it more than the average human I discovered from friends. And that did traumatize me I

> think and it's probably why I had an inferiority complex and some of those other issues. So, I dealt with those traumas, a decent amount when I was growing up, like actual character slandering and betrayal from people who had been close to me for a long time, you know, people you wouldn't expect it from…

Learning and growth. This is the section that Pastor Marie focused on how she has learned and grown in her understanding with mental health stigma. During her time in college, she took psychology classes that she found to be helpful. She also mentioned the different types of mental health issues that she had dealt with professionally in her role as a Chaplain at the call center. These issues included: suicidal ideations, families that were dealing with completed suicide, multiple personalities, chronic depression, anxiety, and even schizophrenia. She shared that she saw "a stigma among pastors where grace was not extended to them" and this made her more aware of how people were unable to see that pastors can also experience mental health problems but will stay silent for this very reason and not reach out for help.

Personal mental health issues. Notes on compassion fatigue were placed in this section. Pastor Marie felt that she experienced a mild case because of other pastors going through the same thing she was able to "notice when she was giving too much and needed to establish certain boundaries." She began to implement and take better care of her own personal needs, allowing herself room to talk with other pastors that had been through this type of experience in their ministry. She explained the following:

> At that point, I, yeah, yeah, it was a mild case of compassion fatigue. I sense that I was starting to get there, and I guess it was a blessing because I could sense when that was starting to happen and I started to deal with it pretty fast. By taking care of my emotional health, setting healthy boundaries… Learning healthy boundaries, understanding fully

> what I could and couldn't help with, you know, and learning to set something aside instead of letting it just stay with me all day and all night. So those were some of the things that shaped me and bring myself into a more emotionally recharged state.

Interview conclusion. To conclude, Pastor Marie had some very wise words to share about her personal and professional experiences with mental health stigma. While she had felt abandoned at times due to friends that let her down, she sees now how God has used these wounds to grow her faith in Him and help others. Even though she has not worked with a counselor personally, she and her husband did pre-marital counseling and found this to also be most helpful in their future together. From her experiences she has "learned to seek out counsel from others who have been in similar situations" and "talks with God to help her process trauma and other life experiences." But she also believes that it is important "pastors know their limitations" with mental health issues in the congregation and that her exposure to mental health has been helpful in understanding this concept.

Pastor Mike

Pastor Mike is a Caucasian, married, Baptist preacher that preaches in the small rural town of Salcha, which is approximately 50 miles north of Delta Junction. He has been preaching for over 30 years and currently is the lead pastor of a tightknit congregation that depends greatly upon him for wisdom and encouragement. He also works with children and has had a long history of helping kids and adults that struggle with mental health issues. Themes that came out of his interview include foster care and mental health, no stigma, life experiences that have led to understanding mental health and avoiding compassion fatigue.

Adverse Childhood Experiences. Pastor Mike's responses to ACE questionnaire were different than the first three. He had experienced at least two but did not feel as though it had

affected his mental health. However, he mentioned that these events did impact how he counsels and help him to be more empathetic towards those who have experienced some of the same situations. The two ACEs that he marked were divorced parents as a teen and inappropriate sexual touching by an adult. Pastor Mike shares:

> I have been in a couple of car accidents, had a near drowning experience as a kid and I was sexually molested when I was a kid. My parents divorced and I have been around a lot of death and dead bodies. Even exposure to just human suffering and abuse and stuff of that nature as you help people walk into their world.

Textual Description. In the interview with Pastor Mike the following ideas became clear as he spoke about his life experiences: childhood exposure to mental health, maturing in the ministry and breaking the stigma. While we chatted, Pastor Mike's passion for kids and adults was evident, and many times he reiterated the importance of shared experiences, commonalities, and being relatable for his congregation and the children he works with.

***Childhood exposure to mental health*.** Pastor Mike felt that during his childhood it was not obvious there was anything pointing towards mental health issues. His parents had their own children but also did foster care for many other kids in the community. However, even though there were some with mental health needs, no one was stigmatized for this, and it was just the norm for others to have these struggles. Pastor Mike did not realize that there was a stigma placed on mental health until he was in high school.

Pastor Mike explains in more detail his early exposure to mental health needs:

> I think in high school when I started, we moved to Alaska when I was 13, or just turned 13. And so, the larger population that exposed me to more kids with special needs, both diagnosed and those were just the ones that were just different, but not necessarily

> diagnosed. Foster care, I think you know, as a child in foster care family they need our help and you are taught to look at them with a little more care than you would just a normal person you consider a peer.

Maturing in the ministry. As Pastor Mike began his ministry in college, he worked with kids "more and more." He became involved in children's camps, daycares and other children's activities. When ADHD was more popularized, he noticed how there became more and more children with this diagnosis. Then eventually he was also exposed to depression, suicidal ideations, and different levels of autism within the spectrum. During his experience with these issues, the stigma was not directed towards the child with the adults because they did not know what to do now. The parents were usually unsure how to approach their child. He shared that

> … by the definition of stigma, the only negative attitudes that I would say was not directed at the child. It was more a negative environmental thing like this child makes me nervous, what do I do, you know, as people are uncomfortable with something that's new and they don't know the parameters of how to speak to him? How do I deal with her?

Breaking the stigma. During his time as a pastor, he has worked with special needs kids and their parents. But there does not seem to be any stigmatizing within his congregation. When asked to share any stories about mental health within his congregation he chose a specific topic of depression. From those experiences he noted that there were many in this category whether it was marriage, or something else, there was always a spiritual aspect to what that person was experiencing. Pastor Mike shares the following:

> ... they are unable to accept or feel hopelessness which is linked with depression. Then there is a significant truth cap due to immaturity or being wrongly misunderstood then they continue to sin over and over.

These individuals have tried fixing it and now they come to him for assistance. To be heard by someone willing to listen and understand. He sees them as trying to meet a standard that God has not asked them to meet. Pastor Mike commented that a

> ... person's true desperation is when they have stopped using their own self-help and want to change using other avenues that include God as their main resource.

Trauma experiences. Pastor Mike shared that as a child he had experienced a few traumatic events. He commented that he had been sexually molested as a kid, almost drowned as a child and his parents divorced when he was a teenager. Then when he went to work in the ministry of helping others there were other moments that had been traumatizing and these included witnessing fellow human beings suffer and seeing many dead bodies. But he understands that this is a part of the job, and he knows God takes care of him through each and every situation. He shares with a kind of disdain for the word trauma,

> … I have been in a couple of car accidents, had a near drowning experience as a kid and I was sexually molested when I was a kid. My parents divorced and I have been around a lot of death and dead bodies… But then I don't know if trauma would be the word, I would use to describe it, but exposure to just stuff of that nature as you help people you walk into their world…

Compassion Fatigue. Pastor Mike spoke of his experiences with compassion fatigue and his defining moment was when he himself noticed that he had not set limits on people helping. He realized that he needed to bring these scenarios to the "light of truth,"

> If I did not deal with or collate those people's stories in the light of Scripture, then I would run into the danger of causing more harm to them and myself. I needed to take each of these individuals to God so that I did not feel overwhelmed or guilty for the ones I was unable to help or bring to a place of peace. Sometimes I wanted to put out a closed sign, but this has helped me to realize I was not meant to fix their burdens but rather walk with each person as they go through their trials.

An example for him is when he worked with a missionary that went to Belarus. During her time there she was exposed to many different sights and sounds that she had not encountered before. Her time in Belarus involved working at orphanages where children were not treated well, and it created a lot of anguish for her. At some point this experience took her to "some deep dark places that she could not crawl out of." When Pastor Mike eventually saw her, she had withdrawn into herself and became a shell of someone that had completely deteriorated with no recourse in finding her way out. She eventually ended up in an abusive relationship, all because she had lost sight of where her strength comes from. This showed him that even the strongest of Christians can get lost and experience compassion fatigue. It also solidified the need to reach out for help.

Conceptual mapping task results. Once the Post-it notes® had been completed and Pastor Mike had an opportunity to look over each one, he took each individual note and with focused intention placed the Post-it notes® in specific areas of the poster board. Once he finished his CMT map, the following topics were grouped together in a stair-like manner: Childhood exposure, ministry development, ministry maturation, invisible elements, and discipleship or maturing of presenting truth. With each one he would explain in more detail as to

what they meant and how they applied to his experiences with mental health and mental health stigma both personally and professionally.

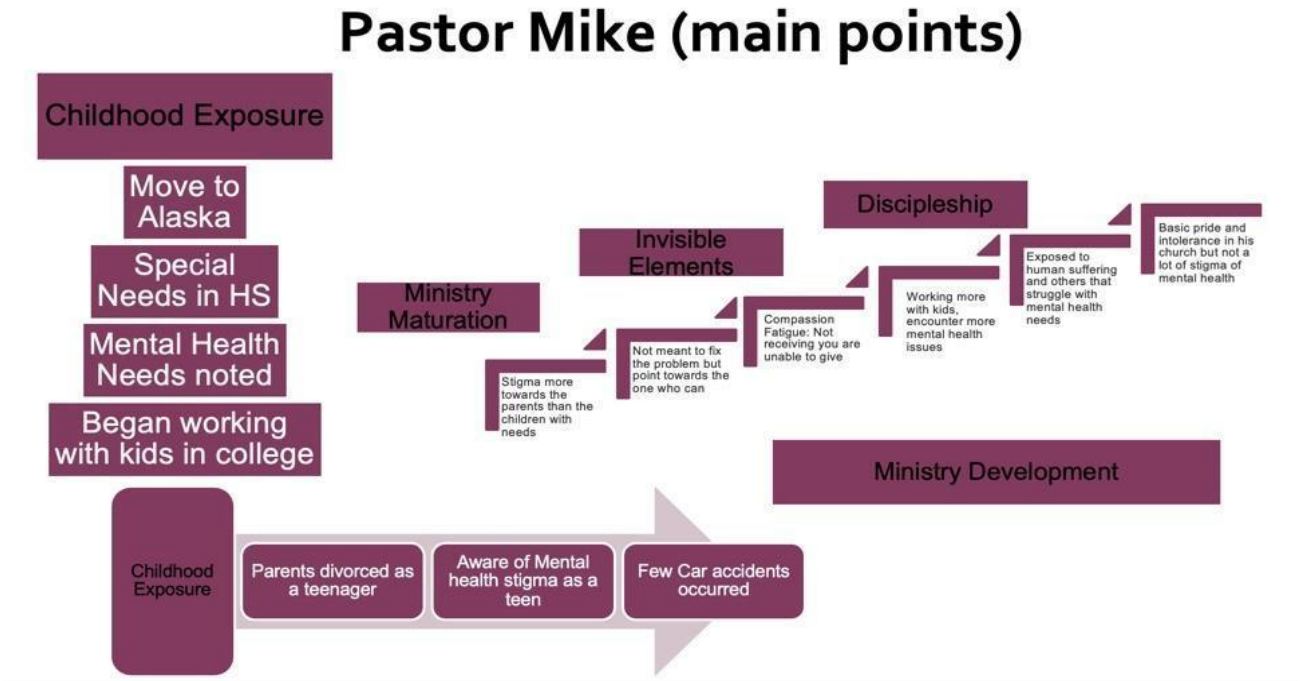

Figure 5: Pastor Mike's Conceptual Mapping task

Childhood exposure. Pastor Mike's CMT creation started at the left side of the poster board and went towards the right. He started with his own exposure to mental health issues that included the foster children that his parents took in during his childhood. He shares:

> … our family ran foster care, okay, and stuff of that nature when it originally came out, but as an understanding or cognitive effect… it was just that (each) kid was his issue or his thinking or the way he behaved. It was not okay to compare somebody with others and say they were different… We ended up adopting one of them, my little sister.

There were many different types of kids that came into his home but the ones with extra difficulties were not treated any differently, even when they were required to take medication. While this was his first introduction to mental health, he was not aware of any stigma at this time

because everyone was treated the same. It was not until he attended high school that he encountered some stigma towards higher functioning special needs adolescents, but for him this was not the norm. Eventually, it was his childhood experiences that laid the groundwork for him to go into children's ministry, and he started this by focusing on kids when he started college.

Ministry development. Moving to ministry development on the CMT map one can see that while he was in college and working with kids, he began to see more prejudices towards mental health as a whole. However, this stigma seemed to be pointed more towards adults rather than children. In college, it was disconcerting to see how adults treated other adults, so he was glad that he chose children as his focus. Pastor Mike describes this in more detail:

> I think in high school when I started, we moved to Alaska, when I was 13, or just turned 13. And so, the larger population that exposed me to more kids with special needs, both diagnosed and those were just the ones that were different, but not necessarily diagnosed. In a foster care family, you are crouched in caring for these people, they need your help, and you are usually trained or taught or should be to maybe look at them with a little bit more care than you would just a normal person you consider as a peer. So, it wasn't so when I started encountering kids with special needs or mental health, whether it be Asperger's or Tourette's or in high school, pretty high functioning on the spectrum. But in my normal teenage mind there were better things to do. But there was definitely a stigma…

Ministry maturation. During his continued time with the children's ministry, he began to use some of the things that he was taught living with foster kids. To be a compassionate person and "deal with their experiences through the goodness of God." He had learned that

when working with both populations you will be exposed to human suffering while walking in their world, but God will give you the ability to get unstuck and help you get out.

***Invisible elements*.** Within this section of the CMT map, Pastor Mike reflected on some of the things that he has learned and continues to use while working with his own congregation today. These concepts came to him at times when he thought he felt that he himself needed some much-needed rest. He said that:

> God will show you that you are not meant to fix someone's burdens, otherwise you will run into many problems trying to fix them on your own. I also learned from moments of doubt that if you are not receiving, then you will not be able to give.

It is these thoughts that have helped him to avoid compassion fatigue and being aware that breaks are a much-needed activity when you feel overwhelmed.

Discipleship or maturing of presenting truth. Pastor Mike shared some of his experiences with children and made the comment that as he worked in children's ministries the more issues he began to see. He noticed that there was merely pride and human intolerances than there was mental health stigma. Even today, as special needs families come to him for support, it's more about fear and the uncomfortable feeling that they get from others than a sense of stigma. He feels this is due to a person's true desperation of their situation and that they can no longer trust themselves but realize change needs to occur. In the meantime, it is Pastor Mike's sole intent to assist them when they do reach out for answers, and help them to "move out of the problem" using the tools he has been given.

Interview Conclusion. At the end of our conversation, Pastor Mike went on to say that it is his goal to help his congregants to deal with what is truth and invite them to see what God expects. He shares:

In this way, they are challenged to look outside themselves and be aware of how their choices are impacting their relationship with God and others.

In his current congregation he encounters many types of problems to include marital discontent, parental struggles, self-harm, retirement transitions, and relationships as a whole. While not all of these are mental health concerns in themselves, they can create mental health issues. For Pastor Mike, that is just a part of what his job entails as a pastor in a small, rural Alaskan town.

Pastor Stockton

Pastor Stockton is a 65-year-old Caucasian male and has been married to his wife for approximately 40 years. He currently pastors a Seventh Day Adventist church in Tok, Alaska and has been their bi-vocational pastor for almost 7 years. But he has been in the Tok community for a few decades, and when the church was looking to replace their last pastor, they chose him because of his willingness to serve and heartfelt desire to live for God. He reflected often during our interview how surprised he was that his congregation wanted him as their pastor even though he does not have any special degree or a lot of education. But as one will see, he has a lot of life experience that he brought with him to this position because God had been preparing him for "such a time as this" (Esther 4:14).

Adverse Childhood Experiences. When Pastor Stockton completed the ACE questionnaire, he reported that he had not really experienced anything traumatic before the age of 18. However, as we continued the conversation, he remembered that is own brother had been sexually molested when he was in 5th grade, but Pastor Stockton was unaware of this till his brother shared much later in life. This event was never reported to the authorities, and he does remember that there was a lot of stress within the family system during that time period, but he

was kept "out of the loop". He is not sure as to the reason but feels his parents were trying to protect him somehow. Pastor Stockton explains in more detail:

> I did not have a lot of stress growing up. I had a brother that was my middle brother was molested as a child and that was as I remember that it was a stressful time in the family. I don't think it was processed legally like it should have been… I must have been probably in 7th grade, and he would have been in 5th grade. Because I was the oldest and I know I am not problematic for sure. But I don't know how involved it was. There was a lot of tears for a while certainly in what all you know what all parents perceived. I was left out of the loop but was unaware of what was going on. I didn't know what had happened until my brother shared with me later in life. I think it impacted him though. It made his life tougher somehow.

Textual description. In the interview with Pastor Stockton the following ideas became clear as he spoke about his life experiences: childhood experiences, mental health exposure, exploring Alaska, trauma experiences, and compassion fatigue. While we chatted, Pastor Stockton mentioned often that he did not feel equipped at times to help others with their mental health issues but showed a desire in learning more about both mental health and mental health stigma.

Childhood experiences. As we began recording the interview and after the consent form had been signed, Pastor Stockton reflected upon his childhood experiences with his family. He noted that his dad was a pastor, and his mom was a teacher. He felt that he had good roots and was fortunate to have a great set of parents. Even though his mom came from a dysfunctional background, she went out of her way to ensure that he and his brothers were well taken care of

and loved unconditionally. His father, whom he looked up to, had a deep foundation of truth that made an impact on him as a child and an adult. Pastor Stockton shares:

> I know that my parents were not perfect, but it is because of them I did not experience some of the horrendous things that other families did while I was growing up. Dad was a religious teacher in a boarding school. I went to grade school there. I did two years my first year so I really only had 11 years and could have quit at 10. Dad was a successful (Seventh Day) preacher; he was the guy that grew churches, he would go some places where there wasn't much and then leave when he had 500 people in the congregation, and I grew up in an easy environment and my parents protected me as a pastor's kid.

Mental health exposure. For Pastor Stockton there really was no mental health stigma or exposure until he became an adult. He does believe that his brother experienced something that was the opposite of his own childhood and realizes that this had truly impacted his brother in a negative way and continues to dictate the decisions that he makes. He does not have a very close relationship with him because of those decisions.

Other experiences involved a cousin that Pastor Stockton was close to. His cousin had been adopted and later struggled with problems in her marriage that he believes has led to depression. The man she married had decided he was gay, and this caused a lot of problems for her family. Then there was someone in his congregation that he was friends with and was diagnosed with bipolar, but this was due to an accident from childhood where he fell out of a tree onto his head. He feels that it is these things that have helped him to be more empathetic towards his own congregation.

Pastor Stockton also shared his own experiences with mental health and depression. He remembers quite clearly how hard it was the first year of moving to such a remote area in

Alaska. This was hard for him because he is usually a very active person, but with the darkness and cold so prevalent that winter, it was difficult for him to have any energy or desire to get out of the house once his wife would finish her day at work. He eventually went to see his provider and was prescribed medication. He felt that it was helpful and was also useful later as a pastor when he would help others who had just moved to Tok.

Exploring Alaska. As we continued the conversation, Pastor Stockton shared how he and his wife ended up moving from his active life on the road to eventually settling in Alaska. He shares that his wife found an advertisement for a job in Tok, Alaska. She is a nurse, and after moving around to many different areas, both were ready to settle down. After a year of waiting, his wife was offered the position of working for the clinic in Tok, and they began the process of moving. He has never regretted this move and has used all his skills as a carpenter, plumber, fisherman, and cowboy to survive and thrive in this vast area of Alaska.

One of the things that he has discovered as a pastor in Tok is that it is like a little community within a community, taking care of one another. In reference to mental health issues in his community he shares the following:

> We have had people too that have showed up before, I think, that were so needy. That they would have just burned us out. You can see sometimes when people come that you know, hey, this is not gonna work. They're in Alaska. They got no resources. They have their kind of users like sometimes, and I think churches attract that to some degree. No fault to the people that are doing it either. It's just they're struggling to find support in life. And so, you lean on the church at times, it can be more than a church can support…

Trauma Experiences. Pastor Stockton reiterated often that he has been very blessed. But he said that if he was to note any type of trauma it would be as a child required to move often from town to town. His father took them to many different places like Montana and Hawaii. As expected, he struggled with leaving friends behind and finding new friends every time they moved. He did not understand at the time, but when he left home he did the same thing because of the type of work that he did. He also loved being around the ocean and "wild weather." Many of his assignments would have been an adventure in and of themselves.

Compassion Fatigue. When asked about compassion fatigue and if this was something that he ever experienced, Pastor Stockton shared that this has not been an issue for him. He feels the reason for this is that he is a bi-vocational pastor for the Seventh Day Adventist Church, and this keeps him from just being focused on the congregation and their issues. He also feels he has found a way to balance these. He believes that part of it comes from watching his dad as a pastor learn to do the same thing. Since his dad was a teacher and had other things that God was using him for, it kept him from being focused on any one thing. Pastor Stockton feels that having these different jobs contributes to that balance. He shares in his own words:

> … I think part of it is that I have an advantage of being an occasional pastor. That is why I do not think my congregation probably does not expect quite as much for me as if I was full time. They know that I am busy. They don't call me for every little problem. If they have a plumbing problem, they certainly call me, you know, and I am okay with that… The congregation is fairly good at taking care of each other. So, I don't have to be there for everybody if there's an issue. I mean, they tend to jump on it themselves, which I'd like to think that's because of my type of pastoring… I have a priesthood of believers…

Conceptual Mapping Task Results. After the interview questions were asked and Pastor Stockton looked over the 50-some Post-it notes® that were collected, he began laying them out on the poster board. As he did this, he spoke about each of the concepts that he was discovering while working on his map. As Pastor Stockton looked over the notes, he was quite surprised to find how much of his upbringing has impacted who he is today. While looking at the notes and a thought occurred to him of how all the "crazy" things he did was preparing him to be a pastor in Tok.

For Pastor Stockton's CMT, there were five major themes that he created after he placed some of his Post-it notes® on the board. He chose the notes that specifically impacted him in his life leading up to his ministry. These included: Foundational truths, God preparation, personal experiences with mental health stigma, transition to ministry, and style types or how he responds to mental health issues in the ministry.

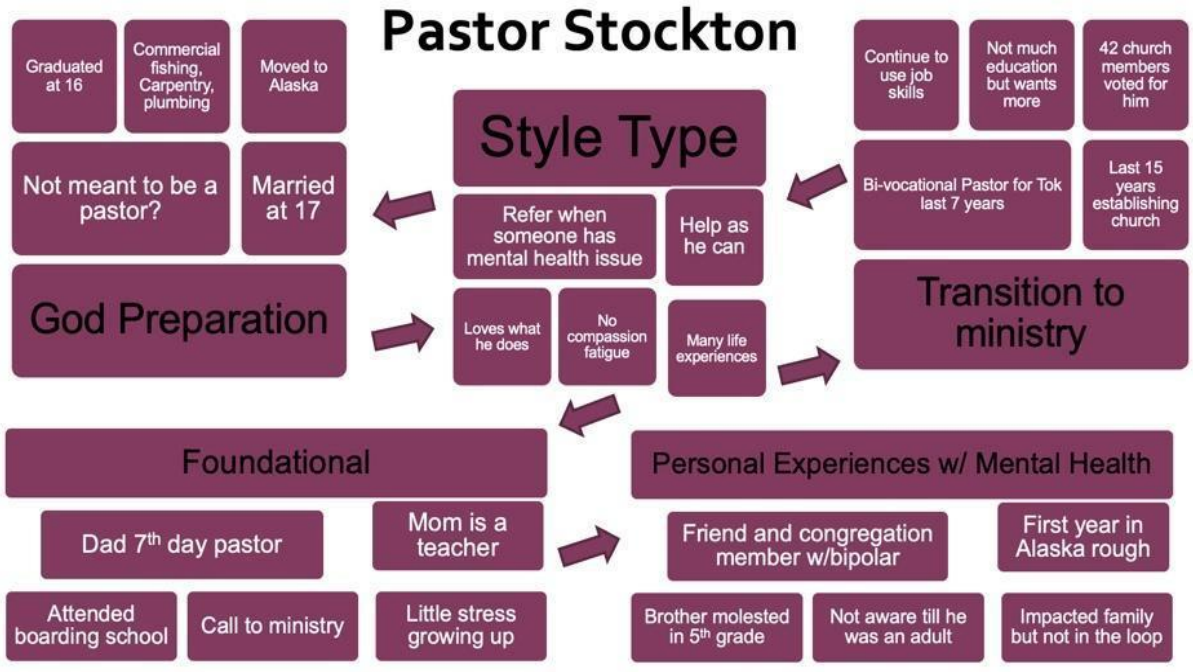

Figure 6: Pastor Stockton's Conceptual Mapping Task

Foundational truths. This section revolved around his childhood experiences with his family and mental health. One thing that prepared him for ministry and working with those with mental health issues was that his dad taught grace. At some point his father and an associate within the Seventh Day Adventist Church began preaching about grace and the righteousness of Jesus. Pastor Stockton reflected on how this grace-based mentality was the opposite of what the Seventh Day believed at the time, which was focused on legalism, but that is not what Jesus taught. He feels that growing up under this truth rather than the one that the church was teaching at the time impacted how he pastors his church now. Pastor Stockton explains this in more detail as he lays out the notes on the board:

> To sort these around I think because of the acceptance I had growing up and following a different path, and perhaps because… of providing a very accepting atmosphere for a congregation. I don't tolerate and I prevent people talking about each other or putting someone down. And I think that comes from my background at home. There was a tendency probably years ago, to be a little more legalistic, you know? With our Sabbath Keepers, which obviously points to the law of God. So, you have an emphasis on the law and we got a reputation as being legalistic. In the 1960s there was a movement that began emphasizing righteousness that comes from Jesus. The man that pioneered this was a pastor named Lee Venden that pushed this concept. Venden was one of my dad's associates and together they traveled and did evangelistic campaigns and emphasized to the point where it could have cost them their jobs because, you know, they were so grace based. So that was the environment I grew up in.

God preparation. As the interview continued and Pastor Stockton worked on finding a place for other notes, he chatted about his experiences after being married at 17. His parents had

no issues with getting married to his current wife; they just were concerned that it was so soon. But Pastor Stockton had already graduated from high school and was ready to begin his life. He had a scholarship to start college but he did not believe he was cut out for higher education. While he remembers being called to the ministry at a young age, he did not think he had the smarts or ability to be a pastor and put the idea aside.

Once he began his life with his new wife and started his family, he also began a circuit of moves that included different jobs and careers. First, he tried milking cows, but that did not work out so well, and he moved on to some other interesting jobs. After working with cows, he became a cowboy and eventually learned plumbing. He also went where fishing was a great way to make good money, especially in Bristol Bay (Alaksa) working with another commercial fisherman. These jobs took him everywhere. He especially believed that none of this would lead to becoming a pastor and felt his parents must have been very disappointed in him because he was not doing anything that would make them proud. Eventually, he began to see how God used these different types of jobs to make him who he is today. Pastor Stockton reflects on this particular time while looking at the CMT board:

> I don't think it would be presumptuous to saying this was prep for the ministry. Preparation and like God was orchestrating it. But at the time I think I actually would have told you I was floundering around. My love was commercial fishing. Well, my call was ministry. And I knew it but I didn't think I would ever have the opportunity because the lack of education and yet in some ways I was getting the education to be the pastor. This was a transition to ministry.

Personal experiences. While Pastor Stockton continued looking over the Post-it notes® and reflecting on his thoughts, he spoke about mental health experiences with his congregation.

He noted that there are about 42 individuals or 9-10 families that attend weekly services. Within his congregation there have been different events that he specifically remembered and was willing to share. In an overall view of problems, he has found that most issues revolve around seasonal affective disorder, marital disputes, and severe mental disorders.

There is one particular issue that he continues to deal with. A person in the congregation, also a friend, is bipolar and struggles with making good decisions. Pastor Stockon remembered a time that this person came into the church while he was preaching and then for some reason got up again in the middle of the service. When someone tried to help him, the individual with bipolar punched the other person in the face. This has been an ongoing problem for a while.

In other scenarios, he has worked with couples that are struggling with domestic violence or alcohol/drugs, and knowing that this was something outside his wheelhouse, he will refer them out to other agencies as needed. Pastor Stockton shared that the Seventh Day Adventist Counsel makes it very clear that as a pastor he is not a professional mental health person and to avoid liability, he needs to make sure to point his congregants in the right direction. But he wonders if he can do more, especially when there are so few resources in his own community. He shared the following:

> With my lack of expertise in the field (of counseling) all I do is recommend people seeking professional help, I guess because I don't feel qualified to be much help… I can see in the time that I have been there we have not lost a member until this past Monday and she was far enough along in years that it was not unexpected.

Transition to ministry. One of his favorite testimonies is how he came to become a pastor for the Tok church. Pastor Stockton shared that when he and his wife first moved to Tok they met another couple. Both couples were of the same denomination and decided to start

services within their house. But it was just a matter of time before the house was not big enough and a bigger facility was needed. With Pastor Stockton's knowledge and skills along with others who had carpentry abilities a new church was built and this made it possible to have a church building without paying rent.

Once the church was built, the Seventh Day Adventist Counsel would send a pastor every 6 weeks to preach and check in on the congregation. However, the itinerate pastor was also responsible for Delta Junction, Fairbanks, and other small communities. But sadly, this would change often and then the last one abruptly died in a plane accident. This led the counsel to decide to put in an ad for a new pastor. It was then that the President of the Counsel suggested Pastor Stockton to apply for the position as a bi-vocational pastor since he had been filling in when the itinerant pastor was not there. To his surprise, his name was added to the list and his congregation voted for him to be their new pastor. He shares the story:

> …This I owe to a conference president that said to apply… A native ministries pastor that sat me down and talked to me and said 'what makes you think you aren't qualified?' you know, you won't know unless you apply. His daughter and her husband were in our congregation and were going through some real crap at the time. The husband was the PA in town and we did not have a pastor so I was the one they would call. He would get drunk and say he was going to shoot himself and I would go visit him. Her dad appreciated what I was trying to do for them, I guess, and kind of thought I was already in ministry and gave me a boost… and I think that is stuff with God's preparation dictated my style of ministry.

Interview Conclusion. Pastor Stockton did not have a life of severe ups and downs but rather a journey where he tried new things and worked amazing jobs. It is from these

experiences along with his childhood that he gained insight into what is good mental health. While he did not experience mental health stigma so much as a child, it was later as a bi-vocational pastor in a very small community that he began to see how this plays out among his own congregation and the people of Tok. But it is because of all these events he is able to understand the importance of mental health and getting his congregation the help. Even if that means he may not be the one to help them.

Results

Theme Development

After following the prescribed methodology from Chapter III, which included the data collection from the audio-recorded interviews, transcripts, and the conceptual maps, the following three themes emerged from the data: (a) *Pastor's challenges lead to greater compassion,* (b) *experiencing secondary trauma leads to understanding mental health stigma*, (c) *pastors' self-care prevents compassion fatigue*. Each of these concepts will be further substantiated in the rest of this chapter. Additional invariant constituents, horizons of experience that did not overlap phenomenological analysis were given for each of them (Moustakis, 1994).

Theme 1: Pastors' Challenges Lead to Greater Compassion. Each of the five pastors shared that their life experiences and challenges played a significant role in helping them have greater compassion for others, especially those with mental health struggles. While the term "ministry development" mentioned earlier in this chapter did not necessarily point directly to the issue of mental health stigma, it was clear that each pastors' struggles allowed them to have a deeper compassion for others, particularly those who may be struggling with mental health issues. It was these important experiences and life challenges that played a role in their ministry and their spiritual growth which would lead to their calling as a pastor. Each had a moment of

recognition about how they could help others as a pastor. Pastor Marie shared this thought while reflecting on her map:

> … looking at this it's just nice to reflect on… My defining developmental life experiences have definitely impacted my learning and has also impacted my life experiences with mental health situations, personally. But this is the thing, also learning and growth from observing and learning from others around me has impacted how I engage as well.

Pastor Stockton also commented while reflecting on his CMT map about developing as a pastor. He noted that:

> To sort these around a bit, I think because of the acceptance I had growing up and following a different path, and perhaps because of the company I've given life with commercial fishermen and people in the building trades, etc., that I tend to try to model and to provide an accepting atmosphere for a congregation… I think that comes from my background at home.

In each interview, all the pastors noted that their experiences as a child, adolescent and/or adult have been preparing them for their current role as a pastor, particularly in working with people who may have mental health issues. According to one study written by Snelgar and associates (2017), spiritual intelligence and intrinsic motivation can be a precursor to a pastor's ministry development. All of them were able to see how these experiences with mental health and mental health stigma have helped them to be more aware of their congregation's mental health needs. Pastor Stockton noted that he would like to learn more about mental health problems. He also shared that maybe the reason more of his congregation does not talk to him

about these specific issues is because they might think he cannot relate or is not able to help them. He hopes to change that.

Each pastor had a different story of life challenges that led them to this time and place in their ministry. Pastor Buffalo originally went to college to focus on farming and even became a sheep herder, but when he was called to preach, he went to Bible college and acquired a degree. Pastor Marie became a chaplain at the early age of 16, but eventually went to college and became a pastor for a Seventh Day Adventist Church. Pastor Mike said his mom and dad were foster parents, which created an interest to work with kids and they became his main focus in school. Pastor Red spent her early life taking care of her disabled brother and realized that she, too, wanted to work with kids, which is what she did. Finally, Pastor Stockton's dad was a pastor, and he thought that this was what he wanted to do as well. Instead, he did commercial fishing, construction, plumbing, and electrical. Believing that he would never become a pastor, he eventually realized God was using all this to prepare him for a pastorate in Alaska.

This first theme relates well with Servant leadership Theory (Greenleaf, 1977) because pastors with different life experiences are going to exhibit more compassion and be better equipped to lead as servants within their congregations. They will have a clearer viewpoint of what life is like and understand the importance of leading from behind. Just as Jesus exhibited compassion and love for us, these pastors, too, will be able to do the same because of their own experiences with mental health and mental health stigma.

Theme 2: Experiencing Secondary Trauma Leads to Understanding Mental Health Stigma. Another theme that was present during the interviews included experiencing trauma and/or secondary trauma. According to Devilly and associates (2009), secondary trauma is theorized to be a cumulative effect upon those that work with survivors of traumatic life events.

This is different from Theme 1 in that traumatic events involve an emotional response to a terrible event such as an accident, rape, or natural disaster and after the event, shock and/or denial become the response (American Psychological Association, 2013). Theme 1 focuses more on pastors having various experiences and challenges that they worked through in their lives. Theme 2 focuses more on each pastor either directly or indirectly experiencing a traumatic event where shock or denial was a major response.

Theme 2 takes life experiences and challenges one step further by looking at how pastors experienced secondary trauma from the people that they work with and how those experiences impacted their views of mental health stigma. By looking at their narratives, each pastor was able to share stories from their own life as well as those of the individuals they work with every day. Each pastor had a story or two about people in their congregation that were struggling with different types of traumas and how they helped them through a mental health crisis or mental health issue. Knowing that mental health stigma can be detrimental to their churches, each have worked towards reducing it in their church congregation and allow space for others to share if they need to. But some of them did not know how other people's trauma could impact them personally until it was too late.

When looking at each of the pastors' lived experiences, each of them also interestingly reported a sibling that was impacted by trauma. Some of them knew what was happening during the traumatic event, while others did not find out until much later. Their experiences of secondary trauma through their family member(s) created compassion and empathy for others and a reduction in mental health stigma for them personally. Each of them also endured an event that opened their eyes to God's purpose for them.

Once he moved to Alaska, Pastor Stockton began doing some soul searching because it was time to "grow up." His first year in Alaska started a bit rocky. He explains:

> My first year here was horrible that way for myself. I remember because when we moved here, we didn't have a home and I was gearing up to build one next spring. My spouse was working at the clinic, and she'd go to work and was under bright fluorescent lights all day and I was at home in a little cabin…. by the time the sun went down at three and by five that afternoon I'm ready for bed. I went to the clinic that year and they put me on [an] antidepressant, and that seem to do the trick, and by next year I was working on a construction job in town.

Pastor Red had a few traumatic accidents in her vehicle that required her to really rely on God and figure out a way to live with the fear that is caused by "almost dying." Pastor Mike witnessed first-hand of another pastor that endured a traumatic situation and how it completely sucked the life out of them. he shared:

> My greatest example of that would be a trip to Belarus with a group of missionaries. I had a summer missionary over in Belarus and she was almost solo and really didn't have a support group. She was going into these dark places of orphanages and just trying to love these kids and just being sucked dry. She was just kind of in her own prison because she could not do enough for these people and for these kids. There was no support, and she was just a shell that had deteriorated into same sex relationships, an abusive one. I think any Christian can get into something like this in a heartbeat when they are not taking what they are dealing with to the Lord.

Pastor Buffalo almost died during a blizzard, and that made him rethink his life goals and where he needed to be. Out of that experience, he went to school to become a pastor. He shared:

> There had been a couple of brushes with death where I didn't think I was gonna come out of it. Both revolved around working on ranches and one was where I got caught in a blizzard and another was an accident. Both made me reconsider life, what was it all about? Would anyone care and would anyone remember me?

Pastor Marie had a roommate that died her first year of college. This was the catalyst for understanding grief and being able to relate to those who experience death on such an intimate level.

> I lost my roommate. I was 17, maybe 18 at this point and in college. She died in her sleep, actually and that was pretty traumatizing for me. I think it made me understand grief better. I have lost people in my life, friends, and family. But that one was really close to home. She was about my age, and this is your roommate and I had hoped we would be friends for life because we had really connected. That was very defining for me when I look back.

Pastors are generally first responders in the wake of most tragedies and different types of mental health concerns by a congregation member (Payne, 2009). Pastors are even considered front-line workers and are contacted more often than psychiatrists or general medical doctors. The primary reason for this is that most people are more comfortable with or familiar with a pastor or clergy over a medical professional. Of course, there are other reasons related to finances and less stigma when it comes to discussing one's personal problems with a pastor. But whatever the reason, most people, especially those who are Christian, will search out a pastor to talk about a traumatic event. At some point, this might cause secondary trauma for a pastor because of what they hear or even see during a traumatic event. Secondary trauma or vicarious

trauma is when the pastor would be in a constant state of tension or preoccupation with people's pain and suffering (APA, 2013).

This theme also relates well to Servant Leadership Theory (Greenleaf, 1977) because when a pastor experiences vicarious trauma, they will have a better understanding and relate to the pain of others in their congregation. Pastors who experience secondary trauma are more likely to express empathy and compassion as they walk alongside God's people as servants. Their experiences with others' trauma can also offer a safe place that allows for change and better outcomes. The five pastors that were interviewed had someone in their lives that experienced trauma and played a huge part in how they lead and serve in their current congregation. Without those experiences, the ability to lead like a shepherd is greatly reduced because it has changed their perspective as servant leaders.

Theme 3: Pastors' Self-Care Prevents Compassion Fatigue. A third theme that came out in the interviews was the idea that each pastor had to find a way to care for their own mental health. If they did not, then they would develop compassion fatigue or burnout, and it would impact their own mental health and their care of the congregation. How would the church congregation know how to care for themselves if their pastor was not caring for himself/herself? This was something a few of the pastors began to realize once they had experienced compassion fatigue for themselves. They learned that there were triggers they needed to be aware of, and that if they did not take care of themselves, it would be difficult to do the same for their own congregation. Each pastor had to find a way to care for their own mental health so that they could be effective rather than ineffective in caring for others' mental health needs in their church community. Even the pastors that had not experienced compassion fatigue understood the importance of taking care of themselves so they could help their congregation.

According to an article by Howard et al (2015), compassion fatigue happens when those in the helping professions experience burnout due to exposure to other's traumatic histories. For this study, the researcher views compassion fatigue and burnout as the same idea. According to one study, burnout is a common occurrence within the church and other helping professions (Burnette, 2016). This type of stress can occur because of intense schedules, conflicts between congregations and deacons, conflicted personal relationships, and the differences between state and local politics. All of this can lead to compassion fatigue because the pastor may not have the support and/or believe there is no one they can lean on.

Pastor Buffalo explained that "it was more me than people. Just reaching my limit but fortunately through teaching and wise counsel from other experienced pastors I knew some of the triggers of what to do. So, I withdrew." Pastor Marie also shared that "… for me the compassion fatigue happened when I was just giving too much, so I, yeah, I just set healthier boundaries and focus more on my, what I needed and making sure I was getting that so I could then minister to those around me."

During the interviews, it was discovered that among the five, three pastors identified compassion fatigue or burnout in their professional experience. However, it is worth noting that the three that had described compassion fatigue or burnout had been to college, were more aware of how it happened, and knew what to do if they experienced burnout. For example, Pastor Buffalo realized he needed to step back from the stress he was experiencing, and Pastor Marie realized that she was giving too much and needed to make changes in her life.

The two pastors that had not experienced compassion fatigue believed this was due to how they approached this problem. Neither had a degree in the ministry, and both had a more laid-back approach to problem solving. When Pastor Red was asked about compassion fatigue,

she explained that she did not experience it because she worked with kids, and they helped her to put things in perspective. Explaining in more detail she said:

> I pray. You know what, to be honest, I think it's because I work with kids. I have had a love for children. Children are the most honest age you can have around you because they do not know how-to put-on façades. And if you come in, ones that say, "what is wrong with you?" Why? Well, you know so you start talking about it with them and they pull you out of whatever it is.

Pastor Stockton shared that it might be that he was "too busy" being a bi-vocational pastor to have time for compassion fatigue. When asked about why he has not experienced it, he said, "I think that my congregation probably does not expect quite as much for me as if I was full time. They know that I am busy. They don't call me with every little problem, and I am okay with that." Pastor Stockton's response and his perspective will be further addressed in the next chapter.

For those who reported that they experienced burnout, they could see the need for change. For Pastor Buffalo, he recognized after the fact that he was "not capable of solving everyone's problems" and that it was necessary to let go of that responsibility, or it would eventually be detrimental to what God had asked of him. He shared what he did that has helped him to cope: "… throughout the ministry career, cancel appointments, if needed, take a day off or a few hours off. But I think the big thing would be recognizing the trigger before it overcomes you and you find a way to overcome it."

Pastor Marie also realized this when she began working with her congregation and noticed how exhausting it had become even after having years under her belt as a chaplain. In her experience most pastors have run into this problem, and she shared that:

> … I could sense when that was starting to happen, and I started to deal with it pretty fast… by taking care of my emotional health… setting healthy boundaries… learning healthy boundaries… beginning to understand fully what I could and couldn't help with… learning to set something aside instead of letting it just stay with me all day and all night.

Burnette (2016) discovered that social support for pastors significantly weakened the positive relationship between job burnout and turnover intentions. These relationships were more statistically significant beyond the main effects of pastor job burnout, social support from the congregation, and the control variables of pastor gender, occupational tenure, pastor job type, and denominational group. This means that if someone has the necessary support, they will have a better chance of regrouping from burnout and hopefully learn from what they experienced. However, the possibility of mental health stigma can increase if those who are in burnout mode do not realize that their inability to get help or deal with the problem shows their congregation that it's not okay to share or get help. Pastors play a huge role in their congregation's ability to seek mental health assistance, but when they are not able or willing to take care of themselves, their people are less likely to.

The theme of self-care preventing compassion fatigue relates to Servant Leadership Theory (Greenleaf, 1977) in that it covers what many pastors may struggle to understand. When a pastor is willing to stop and seek help because they recognize burnout, they are also showing their congregation the importance of taking care of themselves. It is this example in servant leadership that allows the congregation to understand that it's okay, not to be okay. Burnout or compassion fatigue can happen to anyone. Without this understanding, pastors can unwittingly

create a mental health stigma, where asking for help may not be biblical but those pastors who lead by example and reach out to others are the epitome of servant leadership.

Research Question Responses

Q1- What are rural pastors' lived experiences with mental health stigma and what that might look like in their own lives as a leader of their church?

As children, none of the pastors/participants witnessed any mental health stigma in their families, but as they grew into their teen years, that is when things changed for them. For one pastor, it was in high school that he began to notice the stigma towards those who were different because he was not participating in activities that he knew were not conducive to his moral upbringing. Another pastor did not really notice what stigma meant until he began college and had experiences of being around people who struggled emotionally. One of the Seventh Day Adventist pastors experienced stigma firsthand when she saw how cruel others could be if they do not fit in with a particular group.

Each pastor has seen mental health stigma in their own congregations. One pastor, however, did not feel that it was stigma towards the children with needs, but rather it was more about the parents that were struggling. Another pastor felt that his congregation probably experiences this, but because of his current position, there was really no one coming to him to discuss the issue if there was one. Overall, each pastor seemed to be aware of the problem, but for them it was less of an issue than many other problems that are dealt with in their churches.

Q2- How might a rural pastor's lived experiences with mental health stigma influence the way they currently help their congregations' mental health needs?

All five pastors had a laid-back approach to helping their congregations. None of them were looking for issues but waited until someone came to them with a need. While each pastor

has a different type of personality, they still seem to deal with mental health problems in a similar way; by waiting on a person to reach out for help. However, the two female pastors who were interviewed seemed to be more aware of what was going on in their congregation and shared their feelings more readily about how they dealt with mental health issues in their congregations. The male pastors were less descriptive and came across as though mental health issues were not a big deal in their congregation.

Q3- How might rural pastor's lived experiences with compassion fatigue be impacting their view of mental health stigma?

Two of the five pastors shared that they had not experienced compassion fatigue. The other three that did experience burnout did not hesitate to share what they went through and what they learned to combat it. The pastors that did not experience compassion fatigue were able to pinpoint how they kept this from happening. However, it is difficult to ascertain how it is possible to work with people in this capacity day in and day out and not experience some type of exhaustion, especially when congregations have so many people that are in pain both physically and mentally.

One of the main differences between those who experienced compassion fatigue and those that did not was education, which makes it possible that those that did not experience compassion fatigue may not have understood how they were processing those feelings of being overwhelmed. The question to ask is whether this is the reason or if they truly have not experienced compassion fatigue. Either way, based on the interviews, even though not all pastors reported experiencing this phenomenon, it did not mean that they could not relate to their congregation and were still able to understand what this feels like in other ways.

Summary

In summary, there were five pastors that were willing to meet with the researcher. During these interviews, each of the pastors took the time to share their lived experiences in rural Alaska. Each one answered the same questions and then completed their CMT, which was an overall picture of their life experiences with mental health and mental health stigma. The results from each of the interviews brought out three different themes. These included: pastor's challenges lead to greater compassion, experiencing secondary trauma leads to understanding mental health stigma, and pastors' self-care prevents compassion fatigue. From these themes, the three main questions of the study were answered: 1) *What are rural pastors' lived experiences with mental health stigma, and what that might look like in their own lives as a leader of their church? 2) How might a rural pastor's lived experiences with mental health stigma influence the way they currently help their congregations' mental health needs? 3) How might rural pastor's lived experiences with compassion fatigue be impacting their view of mental health stigma?*

Chapter Five: Conclusion

Overview

The purpose of this study was to determine rural Alaskan pastors' lived experiences with mental health and mental health stigma. There were three questions that led each interview: what are Alaskan rural pastors' lived experiences with mental health stigma both in their professional and personal life; how might Alaskan rural pastors' lived experiences influence the way they assist their congregation with their mental health needs; and what type of problematic issues have Alaskan rural pastors experienced working with mental health stigma in their churches? Each of these questions helped guide the research process as other questions were pursued and a CMT map was created.

Throughout chapter five, the primary goal is to look at the three different themes that arose during the interviews with each pastor, and review the relevant literature to emphasize how these themes answer the research questions presented at the beginning of the study. Then an integration of limitations and implications will be added along with recommendations as to what next steps might be when following up with this study.

Summary and Discussion of CMT Pastor Interviews

When living in small, rural Alaskan towns like Delta, Salcha, or Tok, pastors and congregants alike learn the importance of relying on God and one another. Everyone has a choice, but where they get confused or overwhelmed is when they begin to feel isolated and unable to reach out to others for help. However, if they do not rely on God and one another, they will eventually become desperately lost and eventually hate the very place they had hoped to create a home of safety and acceptance.

Five pastors chose to participate in the study. When conducting interviews, there were many issues that came up, either because of COVID-19 or intense weather conditions like blizzards and ice storms. Once each pastor was able to meet for the interview, they provided answers to the research questions and were willing to be vulnerable about what they experienced pertaining to mental health and mental health stigma. It is the researcher's belief that very few pastors were willing to participate in the study because being vulnerable in such a small rural area could be detrimental to one's ministry. Each of the pastors who chose to share did so because they wanted to participate in something that could be helpful for counselors and other congregations.

While interviewing pastors in different rural towns within Alaska, this researcher discovered things that all the pastors agreed upon. Each pastor agreed that they needed God. This covered everything from mental health issues to feeling isolated because of where they are located. Many of the problems that people bring to their pastors were much the same as in other places in the world, including marital discord, depression, anxiety, childhood trauma, and relationship struggles. But each pastor who was interviewed approached the problem from a different perspective. They worship God, but they used their life narrative to help others. For instance, Pastor Marie endured hardship from her experiences with betrayal as a child, and this helped her to understand others in a way that showed more patience than Pastor Buffalo may have. It was Pastor Buffalo's personal trials with stigma in high school that allowed him to see and prepare for when he went to college, and now he can allocate an extra amount of patience for others that experience the same thing in his congregation and community.

Although it may seem that some pastors did not experience anything that might make others believe that they can relate to everyone, it is not everyone that they need to relate to. It is

as though God has placed them right where they need to be to do the work that He has asked them to do. Specifically, as a pastor in a small rural town where many might be very shy about sharing their story, each pastor presented with a certain personality that met those needs, such as someone who experienced the death of a close friend, or a family member that is experiencing a disability. In small rural communities where everyone is known by name, it is difficult to be willing to share such intimate information. But these pastors have a rich life experience by which God has prepared them and has used them in a way that others may not have been as successful. The job of a rural pastor is special, indeed, and each pastor in this study definitely needs to be more patient, more aware, and more understanding than would be normally expected, because those who move to rural Alaska towns come with a kind of baggage that may only be understood by a rural pastor living in that context.

As pastors were interviewed and based on phenomenological tradition, three themes arose (Moustakas, 1994). These themes included the following: Pastor's challenges lead to greater compassion, experiencing secondary trauma leads to understanding mental health stigma, and pastors' self-care prevents compassion fatigue. The CMT is a tool which researchers use to assist participants in putting together thoughts and ideas (Wilson, et, all, 2016). This allowed the phenomenological researcher to hear and respond to these thoughts and ideas with other leading questions to shape and create a visually appealing snapshot of their lives pertaining to research questions.

Mental health stigma definitely exists in the churches of rural Alaska. Whether it looks like people who do not understand what it means or those who are unwilling to change, these pastors are willing to tackle the problem with God's help. While none of them experienced stigma in an extreme way, they each became more aware in their teens and adulthood about the

issues surrounding mental health stigma through their own lived experiences. There is the question of what types of stigmas can or cannot influence a congregation and whether the stigma presented by the pastor is impacting their congregation. Looking at the different themes that came out of these interviews, there are indicators as to what that might look like in the life of a rural Alaskan congregation.

Theme 1: Pastors' Challenges Lead to Greater Compassion

Pastors and trauma go hand in hand. Yet, for some, the word "trauma" is subjective, and they might even question what it means in the context of true pain and heartache. For each pastor, trauma was something they experienced after they became an adult. Pastor Marie learned after starting college that her life was not going to happen as she expected. She lost what she had hoped would be a lifelong friend to an unexpected death. Pastor Mike was clipping along as though he knew what was coming next and was thrown for a loop that completely stopped him in his tracks. This happened a few times as a college student and as a pastor. Pastor Red's life came to a complete halt after two major accidents that left her anxious and fearful of getting back into a vehicle. Even though they may not have experienced the exact same stories as their congregation, any personal trauma or challenge can make someone more compassionate and empathetic. However, if a pastor has not shared about their life challenges, will a member of the congregation be more or less open to reach out to their pastor for help? If a pastor is not open to sharing about their struggles, this researcher wonders if it could create an environment where mental health stigma can grow in a congregation.

What if more pastors were required by their organization to take a class or training about trauma? How might that impact their ministry development and the way that they work with their congregation? When pastors are unable to see how insidious trauma is or just shrug it off as

someone not trusting in Scriptures, there is always potential for more harm and a greater sense of mental health stigma. Just like others in the helping profession like firefighters, medical providers, or even counselors, if there is no training that helps them to dig deep in the world of trauma, not only will they hurt those they serve but possibly even themselves. In a study by Philpott and Stanford (2009), their conclusion was that there is a need for pastors to have more mental health education, and this would include trauma.

Theme 2: Experiencing Secondary Trauma Leads to Understanding Mental Health Stigma.

During every interview with each pastor, it was clear that their past experiences prepared them to be the pastor they are today. If not for the event or situation that they experienced, their lives would be so much different. The time they spent training, learning and being with their congregation has shaped and molded them to be even more equipped to pastor others. But the best part is that each of them wants to go further, learn more, and find ways to help their congregation.

Each pastor had someone in their life that experienced trauma. For Pastor Stockton, it was his brother who was sexually molested. For Pastor Marie, it was a friend who had suffered many losses. Pastor Mike's older brother was molested. These pastors were faced with the trauma of a loved one and experienced that firsthand. All of them mentioned that they could not be the pastor they are today without those experiences, because now when they work with others who have siblings or loved ones that have been through trauma, they can relate.

Theme 3: Pastors' Self-Care Prevents Compassion Fatigue

As mentioned before, compassion fatigue can be a huge problem for most pastors, and it seems that this would be true for nearly every pastor in their season of ministry. Yet, it is hard to believe that someone who has been in the ministry longer than a year would not have some

experience with this unless they had some amazing coping skills. Then there are the pastors who honestly believe that this cannot be a problem because it would mean that they were not relying fully on God. So, they do not get help, or they ignore the problem, which eventually catches up with them. This will then impact not only their congregation but also who they are as a pastor and as a child of God.

As the only counselor of a small Alaska town, this researcher has personally experienced burnout. However, it became obvious that others were also drowning in their own misconceptions that "they can do it all," as Pastor Buffalo would say. Helping professionals, such as pastors and counselors, will have a strong likelihood of experiencing burnout at some point. For caring professionals who are working with this type of pain and have not experienced burnout, or if they say that they are not experiencing secondary trauma, there could be either a lack of understanding or a sense of denial. When looking at pastors who are unable to understand this in their own lives, they may be unsure as to what that looks like and even more unsure as to what they could do to change the outcome.

What was Missing

While there were three themes that were heard throughout each of the pastor interviews, there were also some issues that were not mentioned. One major issue that seemed to be missing from the pastor interviews was the hardship that most every person in Alaska endures. Even though there was an entire section in Chapter II of this study dedicated to describing the lived reality of Alaskan life, not once did any of the five participants complain or make comments about how hard it is to live in such freezing temperatures nine months out of the year. During the winter months of 2021-22, when these interviews were being completed, the interior of Alaska had up to five feet of icy snow that also got swept up by 80 mph winds. While this is not

normal every year, many of the Alaskan winters can be cruel and unforgiving. During the winter of 2022, there were three weeks of -30-degree weather, yet school continued and people went to work. Even Fort Greely, a missile defense and cold weather testing facility, had closed its gates due to the extreme weather.

All the pastors who were interviewed had been transplanted from somewhere else. Even the youngest pastor, who has lived in Alaska for the least number of years, did not talk about the vast differences between the lower 48 and the interior. However, each pastor did refer to the hardships their congregations faced and how they wanted to help them, but none of them mentioned the hardships pertaining to the weather. It is as though there is a "suck it up" mentality not only coming from the pastors but the congregation, too.

This researcher feels that if pastors are not talking about these hardships and the mental health consequences that often come with them, this could potentially keep their congregation from opening up about how hard it is for them, too. What might it look like if pastors were honest about how they are impacted by the colder temperatures and lack of sunlight for many months and acknowledge this hardship to their congregants? What if the pastors were vulnerable enough to talk about how interior Alaska is not the easiest place to live? How might people respond to a pastor that shares their difficulties and is vulnerable about being in such an isolated, yet beautiful place? Is it possible that this is creating an environment of mental health stigma, making it impossible for congregations to feel as if their pastor can relate or try to understand what they are experiencing?

Living in rural Alaska, one will find that childhood trauma is a huge problem due to lack of resources, adults that make poor choices, and many parents who have their own horrific histories. Yet as mentioned before, the pastors that were interviewed reported few or no ACEs.

Could this lack of experience potentially create a stigma around mental health within the church if pastors have little background with trauma? Will the lack of childhood history with trauma make it difficult for the pastor to relate, and if so, could it keep the congregation from reaching out to their pastor? On the other hand, would a pastor with three or more ACEs be overly compassionate and unable to create boundaries with their congregation because they have a need to fill, and this ultimately leads to their own burnout?

While interviewing these five pastors, there was an understanding that most pastors have something or someone that motivated them to be who they are today. This led them to seek out education in the field or simply become ordained as a pastor for their congregation. But this researcher wonders what happens when other pastors without trauma in their life lead congregations that have a collective traumatic past. Will this lack of experience be hurtful or helpful within their congregation?

When thinking about what it has been like to live in the rural parts of Alaska and its hardships, one may be inclined to note that people do not talk about how difficult Alaskan living is. Those that do talk about it generally do not stay around. If people go to Sunday services, listen to the pastor preach about Scripture, but do not hear their pastor talk about life struggles, it could easily translate to greater mental health stigma. Some people who struggle with mental health issues may feel that others around them are doing fine. Only they are not fine; they just have this mentality that they must "suck it up." After all, they reason, they made a choice to live here in Alaska.

Is it possible that pastors are unwittingly creating a stigma when they do not talk about the difficulties of Alaska living? Even if this lifestyle may be considered as normal for people, no one is exempt, no matter how much money one has or does not have. However, people who

live in Alaska fail to point out that each person will experience the harsh negative temperatures differently than others (Booker & Hellekson, 1992). It is important to reach out to their family doctor if depression becomes too overwhelming. Or if a church member is unable to feel better on their own, they can talk to the pastor or get a referral to a mental health professional. But preaching from the pulpit could help those who think they need to bury their feelings and "suck it up."

At the direction of a colleague, this researcher had a follow up conversation with Pastor Buffalo. He said that most pastors will arrive in Alaska with the intention of staying a long time. However, he has learned that it is usually within the first year that it becomes evident whether they will be staying longer than that. Pastor Buffalo went on to say that if they make it past the one-year mark, then it means that the pastor will probably be staying. However, most do not talk about it because it is something that everyone goes through. Pastor Buffalo said that it is not a big deal once people make it through their first year. What he meant by this is that once someone has lived at least a year in the interior of Alaska, then obviously there is no problem to talk about. Pastor Buffalo used the phrase "it is what it is" to describe that people need to take life as it comes, even if life is very difficult.

Implications

To determine the implications of this study, it is important to look at who would benefit from understanding the lived experiences of rural Alaskan pastors and mental health stigma. This researcher found it difficult to find other literature that pertained to this topic. The research that was found was limited at best. Other researchers targeting the topic of mental health stigma and the church could find this study important, especially if the focus is on rural Alaskans. The rest of this section will identify implications for pastors, counselors, and the church.

Implications for Pastors

Pastors that are experiencing mental health stigma in their congregation may or may not notice. For some, they are not thinking about how they can help their congregation with mental health issues, but rather, their focus is the spiritual needs of the congregation, not realizing how mental health ties in. This research could potentially help pastors to understand the need for awareness on the topic of stigma and begin their own journey into doing different things. While this study is limited to certain types of denominations and age groups, this researcher believes that the current results could be a catalyst for the necessary changes and even encourage other pastors to do their own studies on the topic, or at least assess the mental health needs of the people they serve.

Another implication is that there are these unknown rules about how pastors must be the strongest, and if they are not, then there is something intrinsically wrong with them. This could potentially create burnout, making it impossible for a pastor to be comfortable reaching out to others for help. Some pastors may feel that if they do look for support, there is something wrong with them. This is likely to occur if they do not belong to a larger organization or if they do not have access to people outside their congregations for support. For example, based on Pastor Stockton's anecdotal observation, unless a pastor makes it through the first year in Alaska, they will not make it at all. This researcher has been in Delta Junction for over 10 years, and no new pastors have moved here during that time.

If new pastors were to move to Delta Junction or another rural Alaskan town, it could be helpful for them to be paired up with other pastors who can rally around them in support of their transition to such an isolated area. Usually, pastors are treated much like others when they arrive in Delta or any small rural town in Alaska. They are expected from the beginning to just be okay

and get used to the isolation because everyone has to. But the reality is that they too will struggle with the changes, the cold weather, and being so far from their home. These realities of Alaskan life mean that they, too, will need a hand in making it through the first year as a pastor in Alaska.

Implications for Counselors

While rural counselors are generally very much aware of local churches in the community and the pastors that lead those churches, this researcher does not believe many see the importance of including pastors as a part of the treatment process (Stanford & Philpott, 2009). Even in this study, it seems that pastors could unwittingly contribute to the mental health stigma of their congregation. But if pastors or counselors were willing to change their focus and work together, both could be significant healing agents for many church communities. Based on what was found during this study, it looks as though a congregation needs a pastor to be vulnerable; otherwise, they do not know how their pastor can relate. If counselors could foster a professional relationship with local pastors, especially those counselors who counsel from a Christian worldview, it could create a synergistic result of mental health and spiritual health working together as one.

Thomas (2011), in a very poignant study, wrote about the importance of pastors and mental health workers collaborating with each other. He continues this conversation by saying:

> ... as a conclusion drawn from this research analysis, clergy persons increasing their acquaintanceship and interprofessional education could enhance their trust with mental health professionals as well as their teamwork and communication skills in interprofessional collaborative practice (Thomas, 2011, p. 110).

This quote suggests that collaboration would not only help the pastors, but also those within the church.

If Alaskan rural pastors continue with the unspoken mentality that mental health stigma is not an issue, there is less of an opportunity for their congregations to consider church as a safe place. If the pastors are willing to look outside the realm of theology and rethink how they can work with their congregations, many more individuals can be helped both spiritually and psychologically. For that to happen, pastors and counselors and those they serve will need to be on the same page.

Implications for Church Congregations

The last group of people that might find this information useful would be those who attend church each week and those who serve as lay leaders. There are many who attend church as a part of their fellowship with God, and their pastor is someone that they look to for guidance, knowing that they have their best interest at heart. Also, as mentioned earlier, for these individuals their pastor is an emergency contact for when there is a traumatic event or a life change that they may want help with (Snelgar, et, al, 2017). Knowing that there is a stigma within the church and feeling comfortable enough to approach their pastor about this could potentially help make changes from the inside out.

Another implication or recommendation may be that congregations find ways to allow their pastor the opportunity to be vulnerable. In some congregations there is the expectation that pastors should be strong and not have many problems. However, what happens in this type of church environment is that pastors eventually experience burnout or compassion fatigue and are unable to be honest with their congregation, or at least a few trusted leaders in the church community. Pastors need the congregation, their prayers, and emotional support as they continue

to be there for the church. What better way for a congregation to show God's love than to be there for their own pastor?

Delimitations and Limitations

There are a few limitations to take into consideration when reading this study. First, it is a phenomenological study, which means that the number of individuals that were recruited were limited. When the research was approved by the International Review Board (IRB) and phone calls to different pastors were made, there were very few that returned those phone calls. Finding emails was almost next to impossible, and only two of the churches on the list had secretaries to return voicemail messages. Pastors in Delta and neighboring towns usually have another job and were not available to take the call or they were not interested in being in the study. Out of the 20 churches that were contacted between Delta, Tok, and Salcha, 10 responded and 5 chose to participate. Some would have been able to do this if it was phone only, but because the study required face-to-face contact, this created other issues. The reason that in-person interviews were necessary was because this study required hands-on activities.

COVID-19 by this point had become a huge problem within the Alaskan interior in fall of 2021. In fact, when interviews were being organized, it became obvious that appointments were going to be canceled and rescheduled often. Out of the five pastors that were interviewed, four of them had gotten sick with COVID at least once. Eventually, this researcher got sick too, and this caused yet another month of delays. Fortunately, there were no fatalities, and everyone was able to heal from the virus.

During this study, there were a few limiting factors to take into consideration. Four of the pastors were Caucasian and one was a Black American. Secondly, two of the pastors were female and the other three were male. While there are many cultures within our community like

Russian, Ukrainian, Hispanic, Hawaiian, and Alaskan Native, this study was unable to find pastors from these communities that were willing to speak about their lived experiences about mental health stigma. However, this is not surprising, because most individuals have moved to such isolating areas so that they do not have to share their life story.

This study does represent a mix of ages from late 20s to 70s, but there was an age gap between 30 and 50 that was not present. While all pastors were married, not all of them had children. Also, the types of religious backgrounds were not well represented either, with two Baptist preachers, two Seventh Day Adventists, and one Pentecostal. This means that future studies may want to recruit a more diverse group of faith traditions, other age groups, and even pastors with younger children.

Recommendations for Future Research

In consideration of the research findings and the delimitations placed upon this study, it is recommended that other groups of pastors are interviewed to get a better understanding of how different nationalities or communities also experience mental health stigma in their churches. Specifically, there are a quite a few cultures in Delta Junction to include Russian, Ukrainian, Hispanic, Hawaiian, and Alaskan Native, and while Delta has some churches for these nationalities, not all were interested in participating in the study. It would be interesting to interview pastors from these cultures to see how they deal with issues of mental health in the church.

Summary and Conclusions

When looking at the results of each pastor's CMT (Conceptual Mapping Tasks) and transcription, it is obvious that while they were all different, they also had some similarities. They all want to help others, but they all have different perspectives on how they assist their

congregation. Some take a step back and wait, while others step forward and reach out to help. It seems that all of them have gained a healthy perspective on how to take care of themselves, so they are able to live out boundaries with their congregation. All of them have learned the importance of leaning on someone else when their ministry becomes overwhelming. All of them have learned that they also need God as their sole source of help. Mostly, each pastor wants to bring others to Christ, even in the midst of their troubles, so they can be a witness for the true love of God.

These rural Alaskan pastors are great examples of what servant leadership should look like. Based on the definition of what Greenleaf (1977) created in his theory, each of these pastors are going above and beyond what is expected of them. In fact, it is their walk with God, spiritual discipleship and desire to help their congregation that shows true servant leadership and is precisely what Jesus was referring to when he talked about the first being last and the last being first (Matthew 20:16).

It is this researcher's conclusion that while pastors want to be a light for their congregations, this may not always be the case. While they are trying to ensure that God is first place in the decisions of their congregation, they may still be leaving out some important aspects of what their people need to hear, so that they know it is okay to share. There are a lot of questions that were not answered within the context of this study, but others who choose to research this topic may want to consider the following. First, what is it about rural areas that may keep pastors from being honest with their congregations? Second, what would pastors need to be educated on to make those changes? Third, does burnout keep pastors from wanting to be vulnerable with their people?

It may be these and other questions that need to be answered to help our pastors and their congregations understand that it is the stigma of sharing and being vulnerable that keeps them stuck. This stigma of needing to have it all together or not sharing difficulties only causes depression and even more heartache. Once rural pastors begin to recognize their part in this stigma, then more of their own people will be willing to reach out and get the help they truly need.

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Appendix or Appendices

Appendix A

Email survey to Potential Participants
Hello,
My name is Josie Barry and I am a doctoral candidate at Liberty University working on my dissertation and I am contacting you because you are a local pastor in rural Alaska and you may fit the qualifications for my participant pool. To see if you might qualify, please answer the following questions:
1. What is your gender?
Female
Male
2. Which of the following best describes your current relationship status?
Married
Widowed
Divorced
Separated
Domestic partnership or civil union
Single, but cohabiting with a significant other
Single, never married
3. How old are you?
4. What is your racial or ethnic identity? (Select all that apply.)
African-American/Black
East Asian Hispanic/Latinx
Middle Eastern
American Indian/Alaskan Native
Pacific Islander
South Asian
Southeast Asian
White
None of the above (please specify)
5. What church or denomination do you currently serve as pastor?
6. Are you willing to participate in a face-to-face interview for about 60 to 90 minutes?
Definitely would
Probably would
Probably would not
Definitely would not
7. In case you are selected as a potential participant for this study, how can I contact you?
Name
E-mail address
Phone number
8. How long have you been a pastor?
0-10 years
10-20 years
20-30 years
30-40 years or more

9. How many people do you serve within your church?
10-50
50-100
100-200
10. In the past 10 years have you encountered anyone in your congregation who experienced a mental health crisis? Such as anxiety, depression, bi-polar, PTSD, marriage crisis, grieving or bereavement, etc… Briefly describe this situation(s) below.

Appendix B

Phone Interview for Potential Participants

Hello,

"My name is Josie Barry, and I am a counselor at Hats of Wisdom in Delta Junction. I am currently working on my doctoral degree in counseling at Liberty University. I am contacting you to discuss a major research project that involves mental health stigma in the Church. I recently sent out emails to pastors in our community to discuss the possibility of participating in a doctoral dissertation with Liberty University and was wondering if you received that email? If not, would you be willing to answer a few questions to see if it is something that you might be interested in?" (Then I would ask the same questions that were sent via email (Appendix A) and set up a time for them to participate in follow-up questions if they meet the necessary criteria from the first stage or finish up with the other questions to help with determination).

If the pastor received the email, then I would ask,

"Do you have some time right now for a couple of follow-up questions to determine if you might be a good fit for the study?" If they agree, then I would say the following:

1. "If you could spend an hour with anyone in the world, either in history or in the present, whom would you choose?"
2. "I am interested in your choice of the person you chose. Please talk about the individual and what inspires you to spend time with him or her".

Once those two questions are asked then I will either set up a time to meet with them at their office for the study or I will tell them that I am very thankful for their time and contact them by email if I have any further questions for them.

Appendix C

Follow-Up Email Notification of Study Participation

Hello Pastor _____,

Thank you for being willing to participate in the following study: Alaskan Rural Pastors Lived Experiences with Mental Health Stigma. I wanted to send you a reminder of the date and time that we set up and to see if you had any further questions. If so, please email or call/text me and I will get back to you as soon as I can.

I also want to send you the questions that will be asked during the study so that you have some time to think about your answers. And to let you know that our time together will be recorded so that nothing will be missed when it comes time for me to type up the final results of the dissertation. All recordings will be destroyed once the paper is complete.

Thanks again,
Josie

Appendix D

Interview Script

Phase I - Demographic Information

"Thank you for your willingness to meet with me. As we begin, I would like to share an *Informed Consent Document* with you, and for the next few minutes we will read through this document and I can answer any questions you might have". (Read through Appendix E and answer questions. Sign consent form and make a copy for the participant and for the researcher.)

Other demographic information:

"For the first phase of this interview I will be giving you a questionnaire based on the ACE survey or Adverse Childhood Experiences. There are 10 questions for you to complete before we move on to the next phase".

I will then give the participant a copy of the ACE questionnaire for them to fill out on their own.

The participant will answer the following questions:

Before your 18th birthday...

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or ever hit you so hard that you had marks or were injured?
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
6. Were your parents ever separated or divorced?
7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
10. Did a household member go to prison?

Phase II

"I will now start the audio recording. (I will then turn on the audio recording and test the equipment to make sure that it is working properly).

We are now going to spend the next 60 to 90 minutes in an interview where I will be asking you questions and probing for more information from these initial questions, and we will walk

through a conceptual mapping exercise, which is simply a very easy visual exercise that will help you organize the story you tell. There are no wrong answers to these questions and I encourage you to take your time and think deeply about what you would like to say. As a researcher, I am very interested in your story about how you have been impacted by mental health stigma both in your personal and professional life. I will ask some questions, solicit answers, and then probe deeper at times for more information. Do you think that you are ready?" (I will then make sure that each participant is ready and that there are no further questions at this time.)

Questions

"During this phase of our interview, I will be recording key ideas, concepts, and different events on Post-it-notes® while you are sharing your story with me. I will first give you two different 3x5 index cards with definitions that I would like you to reflect upon for a few moments and when you are ready, we will proceed and I will begin to record some of your thoughts based on your experiences".

"The first definition that I want to give you is from the World Health Organization". At this time I will hand them a 3x5 card with the following information on it:

"According to the World Health Organization (2019) Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life and can contribute to his or her community".

"The second definition that I want to give you is from the Mayo Clinic". Then I will hand the participant the second index card to read.

"According to the Mayo Clinic (2011) stigma is 'when someone views a person in a negative way because they have a distinguishing characteristic or personal trait that is thought to be, or actually is, a disadvantage (a negative stereotype)'. When those negative attitudes and beliefs are directed towards someone with a mental health condition it is considered to be stigmatizing".

"Now based on those definitions of mental health and stigma, I would like you to take 10-15 minutes to reflect upon your lived experiences with mental health and mental health stigma, both personally and professionally in your role as pastor in the church."

After waiting a minute or two… "Now when you are ready please share with me your story of lived experiences with mental health stigma". Then while they are speaking, the researcher will write down their experiences on Post-It-Notes®, with one concept per note.

The researcher will encourage the participant to share instances of lived experiences both personally and professionally in the church. The following questions may be asked if the participant is not sharing much about their personal experiences:

1. What have been your lived experiences with trauma?
2. Have you experienced compassion fatigue? If so, what led up to it and how did you choose to help yourself at the time?
3. Have you ever sought out counseling from a mental health provider? What was your experience?

After answering the initial questions, the researcher will say the following: "I would like you to take a look at each of these Post-it notes® and make sure that these details are accurate and a proper reflection of your experience. Are there other details that you would like to add?"

If there is anything new then the researcher will add more Post-it-notes®.

The researcher will continue until the participant says that there are no new details at this point.

Phase III
Conceptual Mapping Task

In this third part I will have the participants putting the Post-it-notes® on a poster board.
"Now that we have all the details checked and reviewed, I will give you this poster board and I want you to take each of these Post-it notes® and arrange them on the poster board in a way that represents your lived experiences with mental health stigma and how these concepts on each of these sticky notes relate to each other"
The researcher will give advice sparingly, but encourage the participant by saying that there are no wrong answers, etc.
"Once you arrange all these notes on the poster board I would like you to please draw a geometric shape around each of the concepts you have chosen using shapes like a circle, triangle or square. While you are doing this activity feel free to move the notes around anywhere you would like and make comments as you move them".
I will then hand the participant a Sharpie pen and have them draw geometric shapes and make note of any comments that are mentioned by the participant.
After the participant has had time to work on this part of the study and no longer has anything to add I will continue on to the next phase.
"Then when you are ready please label each cluster of concepts and feel free to make more comments as you go. Finally, draw lines that connect the cluster concepts to each other and if there is any directional flow between the concepts, please note the direction of those arrows. Again, take your time and feel free to make more comments as you go".
Once the CMT creation is finished the researcher will ask the following questions:

- "Now that you have created this conceptual map about your lived experiences of mental health stigma both personally and in the church please take a few minutes to reflect upon the map itself. (Pause until the participant indicates that they are done reflecting.) What strikes you as you study the map that you created?"
- "How do you think your personal experiences of mental health stigma have impacted the way you help your congregation and their mental health concerns?"
- "What do you see as the most important things to know or understand about your experiences with mental health stigma?"
- Additional probing questions may be added here as deemed appropriate by the researcher to gather more rich data from the participant. The researcher will ensure that the additional probing questions naturally follow the research questions for this study. (Once the participant has had the opportunity to answer the questions, conclude the interview by saying:)
- "Thank you so very much for sharing your experience with me. Your willingness to share your time with me for this project is very important and I am ever so grateful. As mentioned previously, this interview has been audio recorded and I want to remind you that this recording and your conceptual map will be described in a way that will protect your anonymity. If there ever comes a time when you have concerns about confidentiality regarding the conceptual map and your audio recording please let me know. Thank you again for participating and please contact me if you have any concerns that you need to discuss".

Appendix E

Informed Consent Document
Project Title: Rural Pastors Lived Experiences with Mental Health Stigma in the Church.

Principal Investigator: Josephine Barry, LPC, EDd Candidate, - Liberty University
Co-investigator: John King, PhD, LPC, - Liberty University

Invitation to be Part of a Research Study
You are invited to participate in a research study. In order to participate,

- You must be a pastor/clergy member with no less than 10 people in your congregation
- You must be a pastor with parishioners that have experienced mental health concerns
- You must be a pastor of a Protestant church
- You must complete a pre-study Survey Monkey survey
- You must be open to talking about your lived experiences with mental health

Taking part in this research project is voluntary. Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the study about and why is it being done?
The purpose of the study is to investigate Alaskan rural pastors' lived experiences with mental health stigma and how their experiences may influence the way they help those in their congregations that struggle with mental health concerns.

What will happen if you take part in this study?
If you agree to be in this study, you will be asked to do the following things:

1. Complete a pre-Survey Monkey survey to collect information as a pre-screening procedure. Estimated time: 5 minutes.
2. Have an initial phone call as a preselected potential participant. Estimated time: 15 to 20 minutes.
3. Participate in a face-to-face in-depth interview where you will share your lived experiences with mental health. Estimated time: 60 to 90 minutes.

How could you or others benefit from this study?
The main benefit to you from participating in this study is a better understanding of how pastors' lived experiences may impact the way they help their congregation with mental health issues.

What risks might you experience from being in this study?
If you decide to participate in this study, you may face a minimum risk of emotional or relational discomfort. This researcher will pay attention to the potential for emotional discomfort that you may experience, but as with any research, there is some possibility that you may be subject to risks that have not yet been identified. If at any time you have concerns about your involvement, including during the interview, it is completely within your power to stop the conversation.

How will personal information be protected?
The records of this study will be kept private. These steps will be taken to protect the participants: Initial phone calls to potential participants will be done in a private room; interviews will occur in private room l; during the audio recording, identifiable information will not be used; the research reports/findings will use pseudonyms when making reference to the subject interviewed; and recordings and transcripts will be destroyed immediately if the participant withdraws.

Research records will be stored securely, and only the researcher and the co-investigator will have access to the records. Because the participants' narratives will be recorded, raw data will contain identifiers. However, all the data collected will be kept confidential and locked in a password-protected flash drive. Additionally, the codebook that will be used to identify participants and their pseudonyms will be kept locked in another secure flash drive. Further, pseudonyms will be used to make reference to the subjects interviewed when presenting/publishing the research findings.

To record the interviews, the digital app Otter will be used; it will capture valuable information communicated verbally and will also generate a 100% automated transcript. Otter's transcripts are password protected through two lock features—the device's access code, and the app's access code. A final step will be transferring all data to a password-protected flash drive and then deleting all files from Otter's app. Additionally, the flash drive will be stored in a locked cabinet. All information obtained about you in this study is strictly confidential unless disclosure is required by law. The results of this study may be used in reports, presentations, and publications, but the researcher will not identify you.

How will you be compensated for being part of the study?
The researcher wants your decision about participating in this study to be absolutely voluntary.

Is study participation voluntary?
Participation in this study is voluntary. If you decide to participate, you are free to not answer any questions; you may also withdraw at any time.

What should you do if you decide to withdraw from the study?
If you choose to withdraw from the study, please contact the researcher at the e-mail address/phone number included in the next paragraph. The data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?
The researcher conducting this study is Josie Barry, LPC, and the name of the co-researcher is Dr. John King. You may ask any questions you have now. If you have questions later, you are encouraged to contact Josie Barry at xxx-xxx-xxxx or xxx@liberty.edu.. You may also contact the researcher's faculty sponsor.

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

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), you are encouraged to contact the Institutional Review Board at Liberty University (mail address) or via e-mail at irb@xxxx.edu.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

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

The researcher has my permission to audio record me as part of my participation in this study.

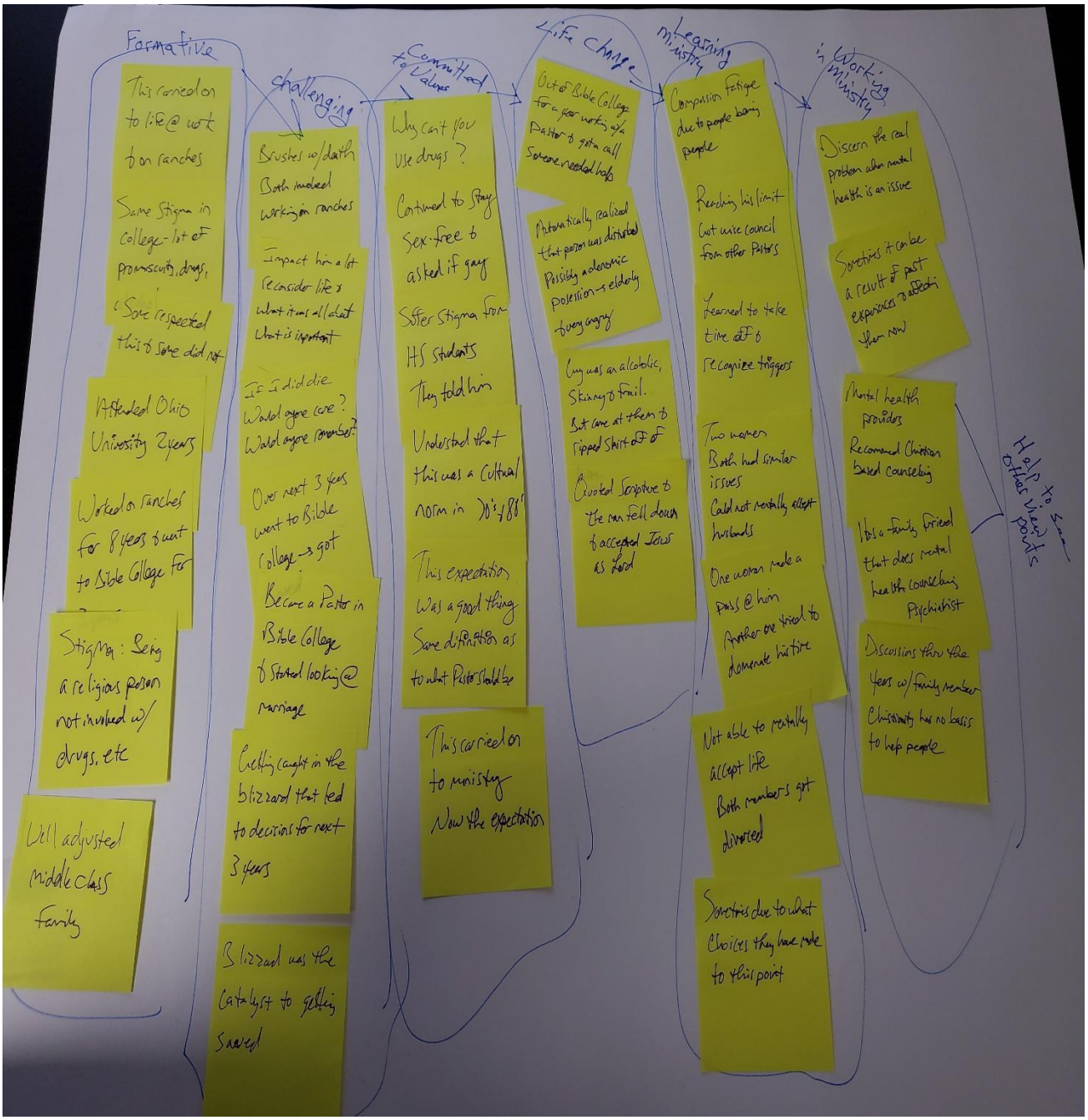
_____ _____

Signature Name Date

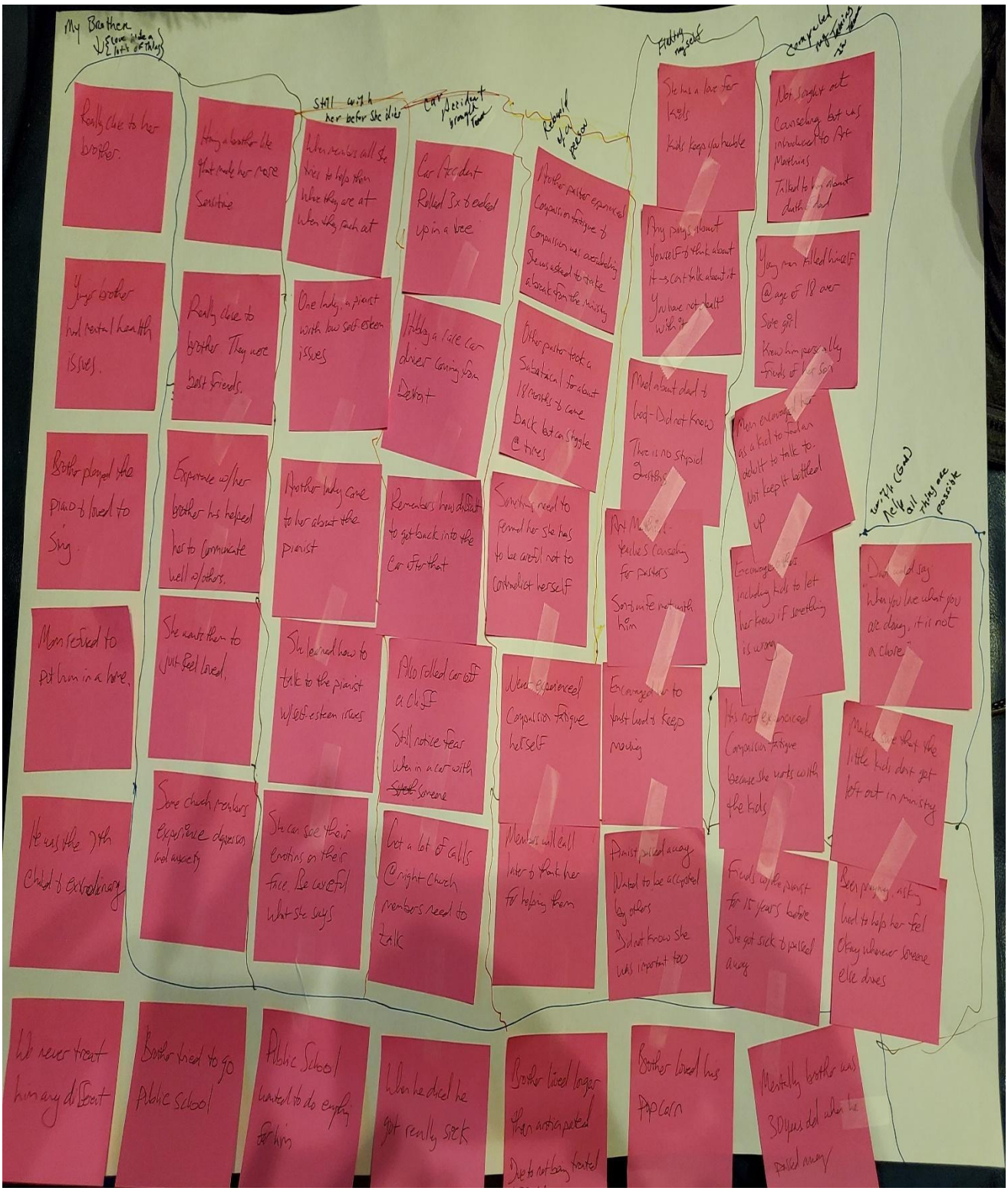
APPENDIX F

Original CMT Pastor Maps

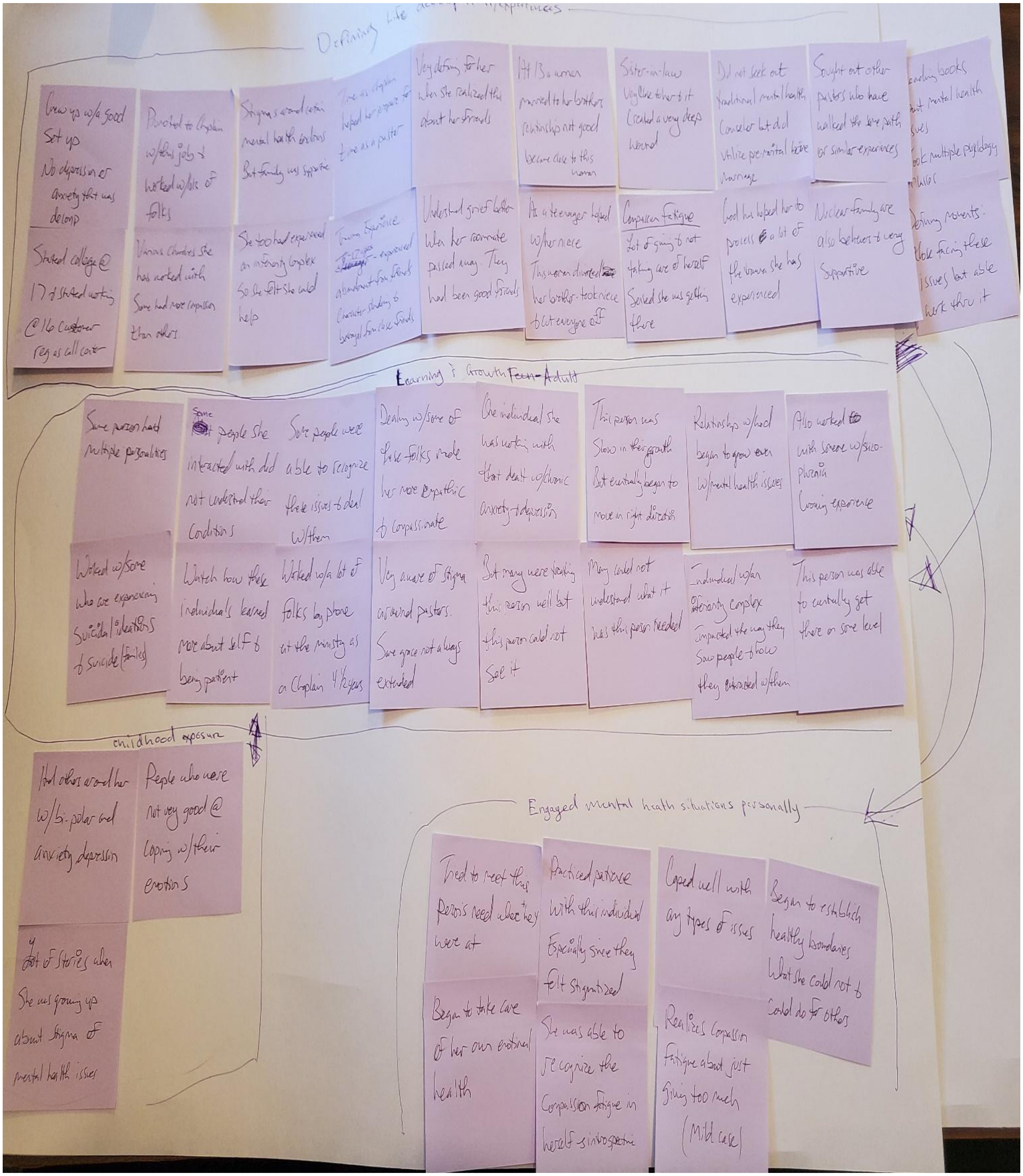
Pastor Buffalo



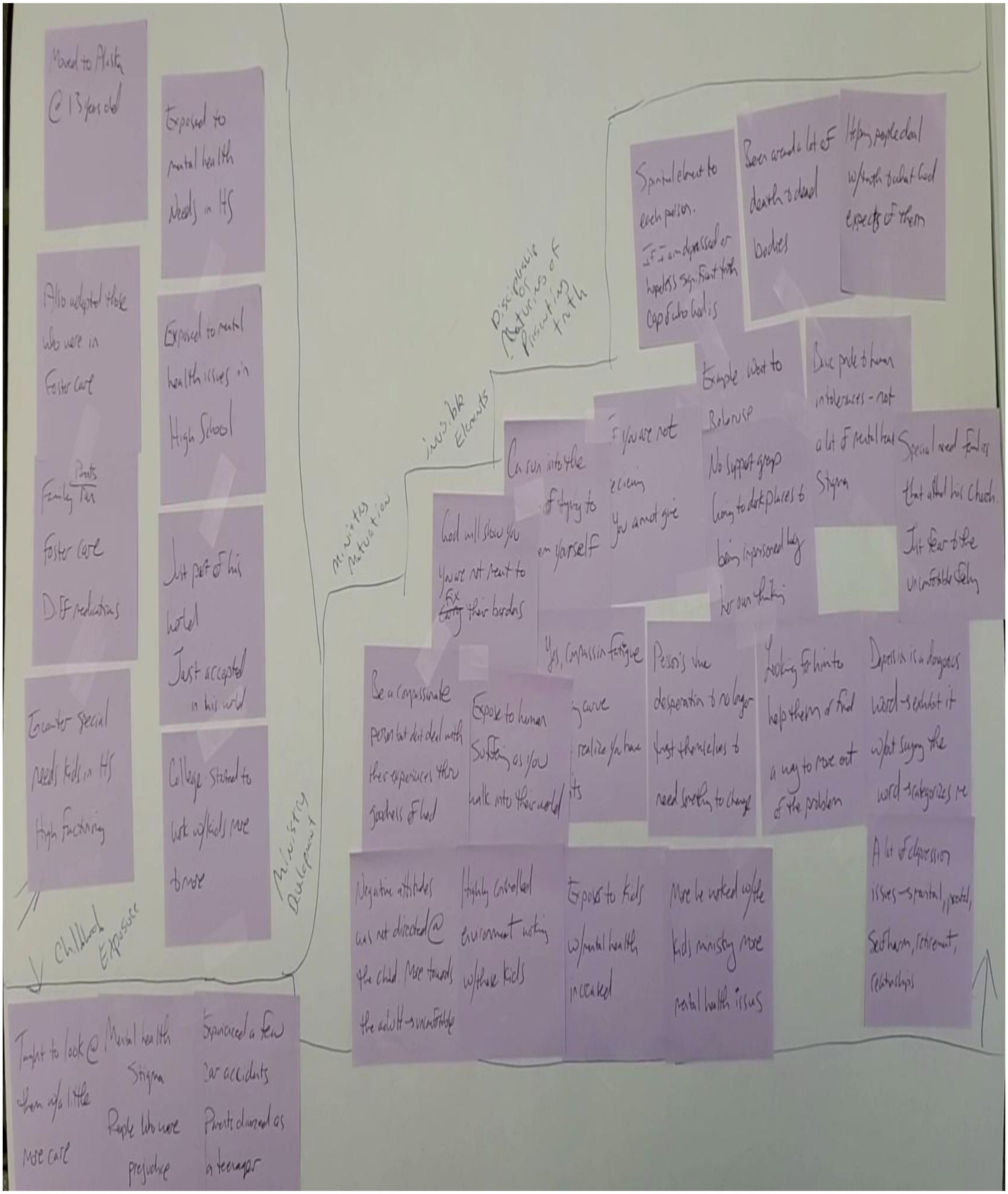
Pastor Red



Pastor Marie


childhood exposure
Engaged mental health situations personally
Coped well with any types of issues
Began to establish healthy boundaries
What she could not & could do for others
Realizes Compassion Fatigue about just giving too much
(Mild case)

Pastor Mike


Moved to Alaska @ 13 years old
Exposed to mental health Needs in HS
Exposed to mental health issues in High School
Foster care
Just part of his world
Just accepted in his world
Encounter special needs kids in HS
High functioning
College Started to work w/kids more & more
Childhood Exposure
Ministry Development
Ministry Maturation
invisible Elements
Taught to look @ them w/a little more care
Mental health Stigma
People who were prejudice
Experienced a few car accidents
Parents divorced as a teenager
Spiritual element to each pastor.
Been around a lot of death & dead bodies
Example Went to Relapse
No support group
Stigma
Special need families that attend his Church.
Just fear of the uncomfortable feeling
God will show you you're not meant to fix their burdens
Be a compassionate person but don't deal with their experiences thru goodness of God
Expose to human Suffering as you walk into their world
Compassion fatigue
Person's the desperation to no longer trust themselves to need something to change
Looking for him to help them or find a way to move out of the problem
Depression is a dangerous word
A lot of depression issues — spiritual, physical, Self harm, retirement, relationships
Negative attitudes was not directed @ the child. More towards the adult → uncomfortable
Highly controlled environment working w/these kids
Exposure to kids w/mental health increased
More he worked w/the kids ministry more mental health issues

Pastor Stockton