AMERICAN CHURCH LEADERS' RESPONSES TO MENTAL ILLNESS

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ABSTRACT

This phenomenological study enlightens the experience between the development of mental illness and the help-seeking of Christian church leaders. Eleven church leaders in Dallas, Texas, were asked to describe their experiences with a mental disorder as church leaders. The theory guiding this study was Heidegger's phenomenological theory. Heidegger's phenomenological approach was the best for exploring the lived experiences of pastors as this theory supports that a person's experience cannot be examined separately from their world system. Three research questions focused on the occasion of a mental health episode while in the role of a pastor in the Dallas/Fort Worth, Texas, area. Data collection for this study included a mental health survey and interviews using researcher-developed questions to examine a purposeful sampling of church leaders who had a mental health episode during their ministry. The data analysis included an interpretative phenomenological method using an idiographic, inductive, and iterative process to create and cluster experiential statements to develop personal experiential themes. The results revealed that in the context of their mental health experience, training and education did not prepare the pastors for the realities of church leadership, including themes related to the problem of stigma in the church, difficulties coping with the overwhelming stress, misunderstandings about the source of mental illness, and the transition into healing and restoration.

Keywords: Christian church leaders, severe mental illness, church culture, support, and recovery

Acknowledgments

I dedicate this dissertation to my Lord and Savior, Jesus Christ, for whom, without His help, I would not have achieved success. He walked with me and provided guidance and practical assistance throughout the research journey.

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List of Abbreviations

American Psychological Association (APA)

Barna Research Group of Ventura (BARNA)

Centers for Disease Control and Prevention (CDC)

Cultural determinants of help-seeking (CDHS)

Diagnostic and Statistical Manual of Mental Disorders, fifth ed. (DSM-5)

Hospital Anxiety and Depression Scale (HADS)

Health Insurance Portability and Accountability Act (HIPAA)

Interpretative Phenomenological Analysis (IPA)

Institutional review board (IRB)

Mental Health Inventory-5 (MHI-5)

Theory of Planned Behavior (TPB)

World Health Organization (WHO)

CHAPTER ONE: INTRODUCTION

Overview

Current research concerning the American Christian church system shows that leaders in the church are under a great deal of stress leading to consequences that include abandonment of their positions and developing the most devasting, severe mental disorders, including suicidal thoughts and actions (Blair, 2019; Lee, 2019). According to Keller (2019), pastors stay in their job because they do not believe they have any other career options, leading to feelings of hopelessness and other mental disorders. Due and Due (2018) stated that pastors must hide disturbing emotions that feed into growing despair and harmful actions. According to BARNA (2020c), the consequences for pastors of remaining in church leadership positions are "43% relationship problems, 20% mental health issues, 75% emotional and mental exhaustion, 37% risk burnout" (pp. 11, 19, 22). In 2021, 38% of pastors considered leaving their job (BARNA, 2021). Another troubling consequence of pastoral stress is the development of self-harm thoughts and actions, as shown by one of several tragic news stories: Baptist pastor Teddy Parker of Macon, Georgia, age 42, passed away from a self-inflicted gunshot on November 10, 2013 (Blair, 2018); he reportedly made statements alluding to feeling stressed, alone, and forsaken by God, his wife, and their two daughters (Weng, 2013). Pastor suicides have continued since the beginning of this research study, with the suicide of church leader Quinnzhahn Barnes by gunshot on October 19, 2019 (Blair, 2019). According to the Centers for Disease Control and Prevention (CDC; 2018), "suicide is the fourth leading cause of death for the age group of 35-54 and the eighth leading cause of death for the age group 55-64" (para. 5). Only "43.3% of adults with mental illness received treatment in 2018" (Bryant, 2018, para. 7). At the time of this writing, the average age of pastors is between 40 and 65 years old; this is concerning given this age range falls within the CDC's high-risk suicidal age groups. Clinical psychologist Chuck Hannaford believed pastor suicides have increased in the 30 years he has treated clients (Zylstra, 2016). Exploring factors

of mentally challenged Christian pastors represents an exclusive chance to discover their formerly undisclosed thoughts, beliefs, and actions.

Background

Historical

The Bible established leadership positions in the church to help guide, teach, correct, and discipline the followers of Christ entrusted to each local congregation (Ephesians 4:11-16; Hebrews 13:7; James 3:1). God did not intend for those in leadership to behave like dictators, where they have sole responsibility for Church functioning (Acts 14:23; Ecclesiastes 4:9-1). Leaders in the church are to operate from the servant foundation established by Christ, who said those who want to have more responsibility for His flock should seek to be servants, not tyrants (Matthew 20:26). The Bible gives direction that the church's leadership roles should be shared with other members, where everyone is equal in authority, but with divergent functions in the Church (Ephesians 4:11). In the Old Testament, Moses and Elijah's stories are examples of what happens when one man tries to keep all the responsibility for leading a group of people. As a judge, the Hebrews pressured Moses to address different problems, stressing Moses. His father-in-law gave him sound advice that Moses needed to delegate the duties to "capable men," or Moses would risk becoming overwhelmed and defeated (Exodus, Chapter 18). Elijah was stressed about the threats from Jezebel and believed he was the lone prophet of God, leading Elijah to become severely hopeless and suicidal as he succumbed to the hopelessness by sitting down and pleading with the Lord to take his life (1 Kings 19:1-4). Thousands of years later, the current leaders in the Church of God are not heeding the advice of Moses' father-in-law or God. Protestant settlers in the 1600s claimed to care about a person's whole health and soul; however, any symptoms of abnormality of a psychological nature were shunned, ignored, or vilified (Vacek, 2015).

Another point is that even though prominent clergies of differing Christian denominations during the colonial years made it a point to explore mental illness, their research/writings delved into

mental health as a general topic, but not church leaders with psychiatric problems (Vacek, 2015). According to Vacek (2015), it was not until the 1920s, when the mental health community was still trying to affirm its viability and reliability as an agent for positive change that pastor Anton Boisen gained direct experience when hospitalized at least four times for psychotic problems. Boisen's initial treatments were not self-selected, as he was involuntarily committed to psychiatric wards (Vacek, 2015). Boisen (1971) made it his life's work to improve the church's knowledge, understanding, and acceptance of mental health as a physiological and spiritual dilemma not to be ignored but supported wholeheartedly by the church. Unsworth (1993) highlighted that church leaders' suicides and mental well-being were not addressed appropriately. Despite technological advancements and the historical work of early pastors who tried to bridge the gap between the church and mental illness, church leaders are still expected to be completely healthy without any psychological or physical problems to be viewed as qualified to lead a church effectively (Gangel, 1994).

Social

Kinnaman et al. (2017) stated, "Pastoring a flock of God's people in such a complex season (lingering wars, poverty, injustice, racial tensions, and political strife) is not easy" (p. 6). Pastors with a Christian worldview succumb to the pressures of navigating a continually changing society (BARNA, 2017). One of the lead roles, pastoral counseling, was thought to be started by church ministers with severe psychiatric problems. According to Hart and Div (2010), Reverend Anton Boisen, one of the "fathers" of the "clinical pastoral movement," had a diagnosis of schizophrenia with at least one mental health hospitalization (p. 537). Others expect church leaders to be above the problems experienced by congregation members, not in leadership positions. Still, depressed pastors do not believe they have anywhere to turn because they fear being judged as faithless and unable to perform their pastoral duties (Aramouny et al., 2020). What is clear from news reports and research studies is that pastors suffer from severe psychiatric symptoms and need help just like non-clergy, but

what pastors do about this before quitting, engaging in illicit activities, or committing suicide is primarily unknown.

The factors between developing mental health symptoms and help-seeking for mental illness in Christian leaders are unclear, and few studies have explored this topic. Heck et al. (2018) sought to understand how pastors dealt with stress through a quantitative survey of 261 Seventh-day Adventist pastors. Heck et al. (2018) assessed the pastors using the Clergy Stress Survey and Ways of Coping Questionnaire. Results showed that this sample of pastors identified "lack of support, financial stress, and time and workload" as the primary stressors, and the ways they coped were "reflective growth/internal change, social/emotional copings, passive coping, and action-oriented coping" (Heck et al., 2018, p. 115).

Salwen et al. (2017) believed that a willingness to self-disclose and spiritual well-being influenced pastors to seek help for mental problems. Still, the survey of 251 seminary students found no connection between these variables. In 2008, Leavey completed a similar qualitative study of the U.K. clergy. Still, the focus was on how ministers dealt with mental illness in their community, not the clergy's psychiatric problems. Leavey (2008) interviewed 32 pastors from various Christian denominations. Pastor help-seeking behaviors have not been studied to the extent that studies have focused on Christian leaders' stress, burnout, sexual abuse, mental health, substance abuse, pornography, and other issues. In 2003, BARNA completed a study of a national sample size of 1344 church leaders to identify the characteristics associated with moral and immoral behavior. The data used are from the "Christian Leader Profile, a 177-question diagnostic" examination (para. 2). Results indicate that the characteristics linked to offensive behavior are selfishness, pride, lack of empathy, and godly wisdom (para. 4). It is essential to identify these character defects early, stated BARNA, "because it provides an early warning signal of pending disasters" (para. 14). The importance of placing these warning signs is to prevent the disasters of pastor severe mental illness, suicide, burnout, and job abandonment.

Lifeway researched depression and suicide in the Protestant church by completing 1000 telephone and 1000 online surveys in 2021 and 2017. According to Earls (2022), Lifeway conducted 1,000 telephone surveys to identify what problems pastors were struggling with; 63% identified stress, and 69% reported relationship problems. In 2015, Lifeway completed 1,000 telephone surveys of Protestant pastors and 355 online reviews of Protestant adults with depression, bipolar, or schizophrenia. In 2015, 23% of the pastors surveyed identified forms of mental health disturbance (Lifeway). Aside from this, Lifeway (2015) reported that 49% of the pastors in 2015 admitted they rarely spoke to their congregants about mental illness. More recently, it appears churches improved in discussing this issue in 2017, with 47% of church members believing their church took the initiative to inform members about psychiatric issues (Lifeway, 2015, 2017). In another study by Lifeway (2015), 48% of pastors believed they could not handle the problems of leading a church. None of the research reports discussed limitations or provided specifics for participants. Lifeway may have discovered one possible reason for the church leaders' lack of initiative for not seeking help. In another one of Lifeway's studies, "48% of evangelicals believe that Bible study and prayer alone can cure mental illness" (as cited in Rainey, 2018, para. 8). An older study by Fellingham et al. (2000) displayed the difficulty in assessing suicide rates in the Latter-Day Saints church. Public records do not always list the cause of death. According to Fellingham et al. (2000), there could be more suicides of church members than realized. These few studies demonstrated the reality of the critical mentality of pastors.

Despite famous statements that there has been an increase in pastor suicides, after hours of browsing popular search engines such as Google, PsycINFO, Schaeffer Institute, and several others, this researcher did not find statistics to support this claim. Descriptors used to search were "Church leaders who commit suicide," "Ministers who commit suicide," "Statistics on pastor suicides," "Female pastors who committed suicide, and "Statistics on Church suicides." Using these parameters only brought up mostly individual cases, primarily pastor suicides. Adding the year "pastors who

committed suicide in 2013" brought up the same stories, many from 2019 and older. This researcher could not find research articles in the APA database. The researcher found a few items on the Religion News Service website. After reviewing hundreds of internet news reports, blog posts, and other web posts, this researcher found 107 suicide cases of a pastor or other person in a church leadership role starting from 1995. The articles indicated many more incidents of church leaders' completed suicides, suicidal ideation, or suicide attempts. However, building a detailed database would take significant time, effort, and funding to understand the problem better. Warner (2009) also identified the lack of knowledge on the number of church leaders with mental illness and suicide attempts and completed suicides. The church's culture of silence around mental health may also contribute to its leaders succumbing to the pressures of their positions (Moll & O'Brien, 2009).

Nine facts stood out from reviewing 107 online articles on incidents of pastor suicides. The data showed all but three were men (Illers, 2021; Mercury News, 2011;). Thirty-three percent committed suicide by gunshot, 22% by hanging or jumping off a building, 12% by overdose or poison, 3 by stabbing or slicing their throat, 2 by burning themselves, 1 by drowning, and 29% of the cases did not disclose the method of death (Bever, 2014; Haitao, 2019; *The Herald*, 2021; Olafusi, 2020; Riollano, 2019; Schnell, 2019; Tracy, 2014). Another significant point is that 67% of the suicides were preceded by stressful events such as unresolved mental health issues or marital and legal problems (News and Tribune, 2016; Novelly, 2017; O'Neal, 2022; Shearer, 2015). This research showed that church leaders are stressed, depressed, and feel hopeless, but what thoughts and actions precede the outcomes of suicide are unclear.

Theoretical

Participants in this study were Christian church leaders purposefully selected from a local community. What these pastors with psychological problems were experiencing within their world of Christianity was primarily unknown. Heidegger's phenomenological philosophy, though complex, at its most straightforward understanding, is that personal experience cannot be investigated apart from

the world in which the person is intricately a part (Horrigan-Kelly et al., 2016) of a person's mental health. People worldwide suffer predetermined consequences leading to severe mental illness and chronic and life-debilitating stress. According to the World Health Organization (n.d.), the quality of a person's life is primarily dependent on a personal perspective rather than external and internal circumstances outside of one's control.

This study explored the phenomenon of church leaders' lived experiences who struggle with mental illness. What is missing from current research is what occurs during the mental health episode that leads to help-seeking tendencies or unhealthy circumstances of troubled pastors. The objective was to gain new insights into what prevents pastors from seeking assistance to develop interventions to prevent burnout and suicidal tendencies. Kinnaman et al.'s (2017) *State of the pastor* report identified that depression and drug addiction are problems some pastors struggle with regularly. Still, there is no mention of what goes on between the mental symptoms and results of suicide and other negative consequences or help-seeking tendencies.

Situation to Self

I attempted to interpret the experience of church leaders with mental illness. This study was grounded in an ontological assumption with a social constructivism paradigm. Social constructivism denies objective truth and posits that social interactions create a person's reality (Endris, 2019). Even though there are cases where mental illness is believed to be developed genetically and biologically, other researchers have identified that psychosocial issues are also contributing factors to psychological problems (Hahn, 2019; Havermans et al., 2018; Heyes et al., 2015; Jacob, 2013; Nestler et al., 2015; Roelen et al., 2018; Xiao et al., 2017). A person also learns by studying personal interpretive life functioning (Research philosophy and assumptions-SOBT, n.d.). This study employed an interpretive phenomenological method. I sought to uncover the church leader's experiences with mental illness. According to the ontological assumption, the best way to gain personal knowledge is to have an explorative conversation.

My interest in church leader mental health is that I have treated those in church leadership positions who present with depression and stress-related problems. A common theme revealed in these counseling sessions is that church leaders feel alone and believe no help is available. I became a Christian in February 2009. My first membership in a church was a Church of Christ denomination. I am no longer a part of an organized church system, although I am still a practicing believer in Christ.

I also experienced a significant period of deep depression for years from grade school to junior high school and know what it is like to feel overwhelmed and alone with external pressures leading to self-harm thoughts and actions. I grew up in a verbally and emotionally abusive household. My parents divorced when I was four years old, my biological father was an alcoholic and drug addict, and I witnessed physical violence between my parents. Because of the chaos at home, I coped by becoming a perfectionist and an excellent student. Despite my troubled home life, I did well in school, graduated high school, and obtained higher learning. I am a licensed clinical social worker and have provided mental health counseling for over 19 years. I have experience treating people with severe mental and substance use disorders. I believe mental illness, as defined in the *Diagnostic and statistical manual of mental disorders*-5 (DSM-5), and the spiritual/supernatural dilemmas mentioned in the Bible are not mutually exclusive. Philippians 4:6-7 (*King James Study Bible*, 1988/2017) says for believers in Christ to be anxious for nothing, whereas the DSM-5 subdivides different forms of anxiety, but in agreement, the DSM-5 and the Bible identify stress as a real problem. The Bible and secular writings differ on the origin of psychiatric symptoms and what to do about them.

I feel the frustration of my patients who report their lack of social support, contributing to their mental problems, including thoughts of suicide. I believe leaders in the church today are under great pressure without adequate help or healing. There are unspoken internal and external barriers to seeking help, and unless addressed, these leaders will continue to suffer alone and in silence. These church leaders should not be stigmatized or afraid of asking for help.

Problem Statement

Research indicates that church leaders are silently struggling with severe psychiatric distress, but how they deal with it is unknown. Current research on the American Christian church system shows that leaders are abandoning their positions at an alarming rate. According to Keller (2019), pastors stay in their place because they do not believe they have any other career options, leading to feelings of hopelessness and other mental disorders. Further research shows that the consequences of remaining in church leadership positions are stress, mental and spiritual issues, and relationship problems (BARNA, 2020c). Despite the growing awareness of pastors' issues, nothing has changed, as a group of researchers reported that over three of four church leaders are working more than the average job holder (Faithlife, 2021, p. 17). The consequences of unresolved mental illness have led pastors to believe that the only solution to their emotional distress was to end their lives by suicide; others abandoned what they had thought was their God-given calling to be a leader in the church. The factors that prevent or contribute to church leaders seeking help for mental health problems are primarily unknown.

Purpose Statement

This phenomenological study explored church leaders' experience with mental health issues and help-seeking behaviors to discover those factors that prevent or contribute to church leaders with psychological problems. Heidegger's phenomenological theory guided this study that a person's existence is driven by time-limited, interwoven, internal psychological, and external worldly processes (Horrigan-Kelly et al., 2016). There is little understanding of the church leader's experience between the beginning of a psychiatric incident and the ending result of adverse life-impacting circumstances.

Significance of the Study

This study is critical because church leaders' stability is crucial because they are directly responsible for their congregations' spiritual condition. Their most vital influence has eternal

consequences. One in 10 pastors is overwhelmed by various issues and has thought of ending their life to overcome the pain (Faithlife, 2021, p. 10). The testimony of a minister killing themselves negatively represents God's saving grace (Romans 2:24). Research focusing specifically on suicidal pastors is sparse. This researcher found only 107 news articles, so the following review of sensitive stories from the public domain highlights several incidents of pastor suicides, demonstrating this issue's seriousness. As this information was published freely on the internet, there were no ethical concerns for potential harm to the families discussing these news stories. In March 2022, bystanders thwarted a pastor's suicide attempt by hanging (Monday, 2022). On September 9, 2019, a well-known Protestant pastor with over 80,000 Twitter followers, 30-year-old Jarrid Wilson, died by suicide by gunshot (Akers, 2020; Schnell, 2019). He lived in Nashville, Tennessee, with his wife and two sons (Alund, 2019). According to Yalden (2019), "Jarrid was a passionate advocate for mental health and suicide prevention" (para. 4). Wilson had established a foundation called Anthem of Hope to be a recovery source for those who have severe mental illness and addiction (Akers, 2020, para. 4). Baptist pastor John Gibson, age 56, from New Orleans, Louisiana, was a husband and father of two adult children. Gibson unselfishly served his local church and community but had issues with depression. He died by suicide because he could not cope with the added pressures of being publicly exposed as part of an adulterous network (Segall, 2015). His wife found Gibson's suicide note near his body; he had written that he was "depressed . . . and very sorry" (Smith, 2015, paras. 1, 3). According to Segall (2015), Toronto police were "investigating suicides" possibly connected to other people's release on the cheating website (para. 8). Another sad news story, Protestant pastor Andrew Stoecklein of Chino, California, age 30, had severe anxiety and depression for which he was being treated by a psychiatrist (Branson-Potts, 2018). Stoecklein spoke to his congregation about mental illness, telling them hope and help were there for anyone who needed it but defied his message when he died from suicide 12 days later, on August 25, 2018 (Branson-Potts, 2018, para. 6). Stoecklein was survived by his wife and three sons (Branson-Potts, 2018). The following are other pastor suicides:

- Protestant pastor Darrin Patrick of Pacific, MO, age 49, died by firearm on May 7, 2020, and reported having had a history of church issues for which he obtained counseling (Holdman, 2020). Patrick was survived by his wife and four children (Smietana, 2020).
- Pentecostal pastor Maria Helena of Vila Kennedy, Brazil, age unknown, was killed by suicide by jumping off a bridge; according to friends, Helena was "sad inside" but presented as stable (Maples, 2019, para. 5).
- Protestant Reverend Song Yongsheng of Shangqui, Henan, age unknown, jumped from a church building's fifth floor on July 17, 2019 (Tao, 2019). His suicide note indicated he wanted his death to impact China's harsh treatment of Christians (Martin, 2019). Yongsheng was survived by his wife (Tao, 2019).
- Protestant Reverend Bryan Fulwider of Altamonte, FL, age 59, was a "co-host for the radio show *Friends Talking Faith*." He was facing life in prison for child sex abuse (Brantley, 2019; Plotkin, 2019). His suicide method on October 17, 2019, was undisclosed (Brown, 2019). Fulwider was survived by his wife and two adult sons (Blair, 2019).
- Protestant pastor Dale Cross of Byron Township, MI, age 66, died by a self-inflicted gunshot on August 6, 2018 (Kolker, 2019). He was survived by his wife, adult daughter, and two adult sons ("Reverend Dale R. Cross Sr. obituary," n.d.).
- Protestant youth minister Allan Richardson of Jacksonville, FL, age 56, died from a self-inflicted gunshot on February 19, 2019 (NBC2.com, 2019). He was being investigated for child pornography (Bourne, 2019). Richardson was survived by his wife and adult son (Blair, 2019).
- Catholic Fryer Martin Sowriyappan of Chennai, India, age 37, dead by hanging (*Times of India*, 2019).

- Protestant lead pastor Jim Howard of San Jose, CA, died from a self-inflicted gunshot on January 23, 2019; he struggled with mental health issues (Virzi, 2019).
- Pentecostal pastor Rodolfo Bacdayan of Umingan, Pangasinan, age 49, died of what appeared to be intentional poisoning; he had conflicts at home (Luzon, 2019).
- Baptist pastor Eugene Keahey of Cedar Hill, TX, age 52, died from a self-inflicted gunshot in a murder-suicide. Keahey's last message minutes before being found dead was, "this difficult time in my life . . . good night y'all" (Heinz, 2019; Smith, 2019, para. 17). According to Smith (2019), "three weeks before his death," he had "changed his Facebook cover photo to a picture with the words 'We all have secrets'" (para. 15). Before shooting himself, Keahey set the house on fire and killed his wife and 15-year-old daughter (Smith, 2019, para. 2). He had also attempted to kill their other 17-year-old daughter. She survived the fire but later succumbed to her injuries (Smith, 2019, para. 3).
- Pentecostal Bishop Berry Dambaza of Harare, Zimbabwe, age 59, died from jumping off the fourth floor of a building; his suicide was preceded by finding his wife in bed with another and reported stressors of caring for a sick mother and financial problems (Masenyama, 2019).
- Pastor Bassey of Mulero, Lagos, age 49, faced charges for dealing inappropriately with church money; he died by self-inflicted knife throat slash (Hanafi, 2016). His wife and son survived him.
- Methodist pastor Seth Oiler of Newark, NJ, age 42, method of suicide not disclosed (Shearer, 2015); before his death, he had admitted to having an affair and was in danger of losing his job (Okonkwo, 2015). Oiler was survived by his wife and three children (Shearer, 2015).
- Baptist pastor Tommy Rucker of Dunkerton, IA, age 54, death caused by a self-inflicted gunshot (Magee, 2014). His family and church had no idea he was suffering, as he did not

voice or show any signs of distress (Magee, 2014). Rucker was survived by his wife and seven grandchildren (Magee, 2014).

- Protestant youth minister Nicholas Henshaw of Fort Collins, CO, age 35, died by suffocation by asphyxiation (Ruta, 2014, para. 3) and was facing criminal charges for child sexual assault.
- Another church leader, Catholic pastor Vladimir Dziadek of Tampa, FL, age 56, committed suicide by hanging on May 12, 2014; Dziadek was reportedly "depressed after parishioners discovered he had embezzled about $200,000 from the church and gambled it away" (Sullivan, 2014, para. 4).
- Pentecostal pastor Vishnu Lutchmansingh of Port of Spain, Trinidad, age 54, completed murder-suicide, self-inflicted gunshot on March 31, 2014 (*Jamaica Observer*, 2014). Before shooting himself, Lutchmansingh had reportedly killed his brother and attempted to kill his nephew (Lee, 2014, para. 2). He had a history of being charged with fraud (Lee, 2014).
- Protestant pastor George D. B. Antrim of Johnston, IA, age 40, suicide method on May 1, 2014, not disclosed (Jackson, 2014). He left behind a suicide note stating he had been suffering inside (Marie, 2014). Antrim was survived by his wife and two sons (Marie, 2014).
- Protestant pastor Isaac Hunter of Altamonte, FL, age 36, self-inflicted gunshot on December 10, 2013 (Breen, 2013). Hunter had committed adultery, and his wife reported he was "unstable, erratic and suicidal" (Religion News Service, 2014, para. 2). He was survived by his wife and three children (Religion News Service, 2014).

These church leaders, who appear to have thought death was their only answer to deal with their stressors and inner torment, seem not to be alone and are part of a more significant problem.

Church leaders have a substantial influence on the lives of their congregations. In Harmon et al.'s (2018) qualitative study, 30 African American pastors talked about how their impact was mitigated through biblical doctrine interpretations, relationship quality with congregations, personal-

social skills, and assistance from the Lord. Pastors are the churches' gatekeepers, including external health-related programs (Baruth et al., 2015; Harmon et al., 2018; Timmons, 2009). Church leaders' influence on their congregations can lead to harmful consequences. One extremely well-known story is about Jim Jones, a reverend who led his group in the Jonestown Massacre, where over 900 people, including children, committed mass suicide (Kennedy, 2020). Although a minister leading their church to acts of this magnitude is rare, there is no question that church leaders wield tremendous power over their members.

One hope of this study is for church leaders to learn that they are not alone in mental distress. The hope is that those struggling with psychological issues may feel confident reaching out for help before detrimental actions occur. With the increasing incidents of church leaders' suicides and quitting the profession, identifying why aid is not sought could help develop preventions and interventions.

There are books on self-care addressing those in church leadership roles. For example, in their book, *Pastors at greater risk*, London and Wiseman (2011) subdivided the usual challenges in ministry and provided necessary recommendations for dealing with them. Pastor McNaughten (2015) exposed his trial with depression in *Confessions of a depressed Christian* and offered practical advice for other ministers with the same problem. These are two examples of self-help books available to church leaders. Many pastors work over 50 hours per week and are expected to be available 24 hours daily, regardless of other commitments or personal needs (Rainer, 2013; Wickman, 2014; Wilson, 2011).

Another point to consider is the advice given by London and Wiseman (2011) and McNaughten (2015). For example, McNaughten (2015) showed 11 "tips" for dealing with depression; one was "tell God about it," implicating that severely depressed clergy are not praying or talking to God about their problem. Many suffering preachers are crying out to God. The issue is that they do not believe He is listening. Kirby Smith (2020) was a Baptist preacher of 35 years, married

with children, yet he suffered from severe depression for 18 years. Smith stated, “Every day I pleaded with God to take away my darkness. God did not” (para. 4). Bryant (2018) said, “you can’t [just] pray away” psychological issues. Michael Wilkes (2019) was another Baptist preacher who divulged his two-year trial after descending into a dark mental and emotional prison. Wilkes stated, “It is not just something you can shake off, pray off, or even just ‘think positive’ faith-filled thoughts and make yourself better” (para. 11).

Smith (2020) cited the ignorance of mental illness as a reason for silent suffering. Wilkes (2019) identified denial about why they did not seek help before the depression overwhelmed them and negatively impacted all functioning. Smith (2020) and Wilkes (2019) recognized a need for more psychiatric training/education and the development of ministry-focused interventions because neither believed they received the help they needed from their local congregations. Are Smith and Wilkes’s reasons for not seeking help the same for other pastors? Exploring this issue was the objective of this study.

Research Questions

RQ1: What are the lived experiences of church leaders with mental illness?

RQ2: What were church leaders’ experiences with help-seeking during their mental health episodes?

RQ3: How were church leaders’ relationships during the mental health episode?

For several ministers, pressures from life events became too much, leading some to consider an act of no return. Pastors struggling with no help are critical because many pastors are strained, depressed, and overwhelmed, as mentioned earlier in this manuscript. The CDC (2018) reported sobering statistics on suicide. According to the CDC (2018), “suicide is the 10th leading cause of death in the United States” (para. 1). Another confirming fact related to this research project is that men commit suicide 3.6 times more than women do, and 52.8% of suicides are by firearms (CDC, 2020). Half of the 23 pastors discussed earlier died by gunshot, and only one leader was a woman.

Also, according to the CDC (2018), the age groups with the highest rate of suicides per 100,000 are 45 to 49 (19.38%), 50 to 54 (20.71%), and 55 to 59 (21.66%). Although the average age of this sample of church leader suicides was 47, the average age could fall between 45 to 59, as 27 of the pastors' age at the time of death could not be found.

Sixty percent of the U.S. general adult population are overly stressed, with work being one of the highest identified sources of distress (APA, 2019). Pastors are not exempt from being stressed with work because, according to Pastoral Care Inc. (n.d.), the average pastor works "between 55 to 75 hours per week," and more than half feel overworked. Chronic stressors are linked to developing severe mental health issues (National Institute of Mental Health, 2019). In an authoritative position, the tension among church leaders has added a layer of stress unknown to laypeople, leading several ministers to devastating consequences. After the death of Jarrid Wilson, Greg Laurie stated, "People may think that as pastors or spiritual leaders we are somehow above the pain and struggles of everyday people..... We are the ones who are supposed to have all the answers. But we do not" (Crary, 2020, para. 4).

Clarifying pastors' struggles with mental illness as church leaders is essential. As mentioned in this manuscript, many pastors are stressed, depressed, and overwhelmed, leading to severe and deadly consequences. In 2001, NMH Communications reported that approximately 66% with a specific psychiatric illness did not get help for mental health concerns (Härtl, para. 2). Recent research indicated that more people are considering suicide at a higher rate. At the same time, over 50% of adults with mental anguish go untreated (Reinert et al., 2020). According to Bryant (2018), 25% of adults suffer from severe psychiatric problems; research on assessing Christian pastors' mental state aligns with other general studies on mental health.

In 2003, Reverend Andrew Irvine completed a qualitative survey of 338 ministers in Canada to identify why pastors struggled with psychiatric issues (Briggs, 2019). The answers to Irvine's questionnaire indicated that more than half had internal turmoil that did not match their external

physical presentation (Briggs, 2019). The pastors in Irvine's study identified a lack of support linked to their upset feelings (Briggs, 2019). Since Irvine's 2003 study, despite increased public awareness of mental health and advancements in the development of effective evidence-based psychiatric therapeutic interventions, the percentage of depressed pastors remains at almost half (Kinnaman et al., 2017; Schomerus et al., 2012; Van Der Kolk, 2014). Pastors continue to be distressed, but there have been limited efforts to develop help for them.

Definitions

For this study's purpose, this researcher chose to limit the definition of "Christian faith" in the following manner (All biblical verses were based on the *King James Study Bible*, 2017 unless other versions are cited):

- The belief that there is an eternal and all-powerful God who is the creator of all things in existence (Felix, ca. 210-230/1974; Isaiah 40:28; Jeremiah 32:17; John 1:1, John 1:1-51; Matthew 19:26; Psalm 90:2, 147:5; St. Irenaeus, ca. 200-201/1920).
- There is only one God in three persons—God the Father, Jesus Christ, and the Holy Spirit (1 Corinthians 8:6; 2 Corinthians 13:14; Ephesians 4:4-6; John 10:30, 14:26, 16-17; Lewis, 1952/2002; Matthew 28:19; Melito, ca. 165-175/2020).
- Jesus Christ is God's eternal, uncreated, human physical form (Colossians 1:15-17; Hebrews 13:8; John 1:14; John 8:58; Melito, ca. 165-175/2020; Nee, 1957/1977; Ph. 2:5-8; Victorinus, ca. 270-310/2020).
- Jesus Christ lived a human life, performed miracles, and gave his life to save people from God's judgment; and died and was buried in the grave for three days but rose from the dead on the third day (Acts 2:22; Edersheim, 2003; Hebrews 4:15; Hebrews 5:7-9; Keener, 2011; Larkin, 1918, p. 49; Luke 2:52; Mark 15:42-45).
- The Bible is God's inerrant message to the world about Himself and His expectations for how one should live and warnings for those who choose to ignore God's laws. (Deuteronomy; 2

Timothy 3:14-16, 3:16; John 17:17; John 20:30-31; Matthew 4:4; Revelation 22:18-19; Hebrews 4:1; Psalm 19:7-11; Henry, 1706/2003; Pink, 1917/2011; Thomas, 2018).

- Humans are not just material beings but also have souls and spirits (Ecclesiastes 12:7; Luke 12:5; Matthew 10:28; 1 Thessalonians 5:23; St. Irenaeus, ca. 200-201/1920, p. 318).
- Heaven and hell are real places that are the eternal destinations for every human (Lewis, 1952/2002; Matthew 25:41, 25:46; Puritan Watson, 1682/2018, p. 18; Revelation 21:1-27, 21:8; Romans 2:6-8; Matthew; 1 Thessalonians 4:13-17).
- Belief in the shed blood, human Christ rose from the dead, identifying as a sinner and repentance from sin proven by obedience to Jesus's commandments (Breaker, 2011; Edwards, 1741/2011; John 3:3, 3:36, 4:2-3; Matthew 6:1-6, 26:28; Romans 10:9; Spurgeon, 1888/2019).
- Belief and submission to Christ is the only way to heaven (John 14:6; Matthew 7:21-27).
- Christians strive to obey God's laws and commandments, do selfless good works, and avoid sin (John 14:15, 21; Joshua 1:8; Luke 13:24; Matthew 7:13-14; Puritan Watson, 1682/2018; Romans 12:1-21; Ryle, 1877/2017; St. Irenaeus, ca. 200-201 CHE/1920).
- Christians are not exempt from the everyday trials experienced by every human living in this world corrupted by sin (Arnobius, ca. 30-600/1871; Genesis 6:12; 1 Peter 4:12; 2 Peter 1:2-4; Ryle, 1877/2017; 2 Timothy 3:12, 3:1-5).
- There is a supernatural world where good and evil angels and demons and other spirits, including Satan, dwell and actively influence humankind (2 Corinthians 12:2; Colossians 1:16; Ephesians 6:12; Hebrews 1:14; Larkin, 1918, p. 17; Lewis, 1952/2002; 1 Peter 3:22; 2 Thessalonians 2:9).

There are several other qualities of a faithful Christian, per the Bible. The Christian faith's qualifying characteristics are based on these few core doctrines. Some areas within the Christian faith have been disputed since its inception. For example, the controversy about women preachers (Brekus,

1996; Deyoung, 2019; Knox, 2003; Melick, 1998; Shaw, 2019) was not the focus of this study. Other definitions are as follows:

1. *Church leader* - Any male or female, 20 years or older, in a leadership position within a Christian church, regardless of denomination. Titles include clergy, pastor, bishop, reverend, minister, or pastoral counselor (Federal Emergency Management Agency, 2020).
2. *Coping skills* - Psychological or behavioral methods used to deal with stress-inducing internal or external events (Schummer, 2019).
3. *Emotional/mood problems* - Overwhelming feelings consistently felt for a minimum of a two-week episode contributing to cognitive, physical, and behavioral dysfunction and suicidal ideation, planning, or attempts (APA, 2013, pp. 155, 161). The most commonly impaired negative emotional states recognized by the APA in the DSM-5 are depression, sadness, hopelessness/worthlessness, excessive anger, complicated grief, anxiety, agitation, irritability, distress, discouragement, emptiness, numbness, and anhedonia.
4. *Help-seeking* - According to Cornally and McCarthy (2011), "Problem-focused, planned behavior, involving interpersonal interaction with a selected [mental] health-care profession" (p. 280) or assistance seeking from non-professional sources such as friends, family, and other lay-unlicensed counselors.
5. *Mental illness/health* - Cognitive, physical, behavioral, and emotional experiences, symptoms, and behaviors are causing persistent difficulties in normal day-to-day functioning and suicidal ideation (APA, 2013; Parekh, 2018). The participant can have a formal mental health diagnosis or self-identified serious cognitive or emotional problem.
6. *Ontology* - The study of the multiple realities of an individual's existence (Burrows, 2000).
7. *Psychosocial issues* - Social issues are interconnected with a person's cognitive, emotional, and behavioral functioning (Enomoto et al., 2012; Van Hoogendoorn et al., 2000). Social factors can include mental (personality traits), emotional issues, social skills, coping skills,

family conflicts, social support, and legal aspects (Chida et al., 2008; Van Hoogendoorn et al., 2000; WHO Commission on Social Determinants of Health, 2008), "education, occupation, income, gender, [and] ethnicity/race" (WHO Commission on Social Determinants of Health, 2008, p. 43).

8. *Quality of life* - According to the World Health Organization (n.d.), "an individual's perception of their position in their life in the context of the culture and value systems in which they live and relate to their goals, expectations, standards, and concerns" (para. 2).
9. *Religiosity/spirituality* - A range of religious-related activities and beliefs believed to impact a person's mental, physical, and emotional state. The activities can be the following: (a) church attendance, (b) study of religious materials/books, (c) prayer/meditations, (d) fellowship and relationships with other believers, and (e) religious beliefs as they relate to a person's view of God (loving versus judgmental), (f) volunteerism, or (g) surrender (Carothers et al., 2005; Clements & Ermakova, 2012; Kendler et al., 2003).
10. *Social constructivism* - Knowledge is obtained, evaluated, and acted upon through social interactions in specific situations (Endress, 2019).
11. *Suicide/suicidal ideation* - Subjective consistent thoughts/beliefs that death solves psychosocial issues, stressful life situations, and medical problems (APA, 2013, p. 161; Choo et al., 2019). Suicidal thoughts can be passive, with no intention of harming themselves (APA, 2013; Simon, 2014). Suicidal thoughts can be intentional, with plans and attempts to harm oneself to end one's life (APA, 2013; Simon, 2014). Self-harming actions include nonfatal suicidal gestures that can be nonhabitual or a regularly employed cynical coping strategy (APA, 2013; Linehan et al., 2006; Rosofsky, 2009), for example, superficial cutting (without the intent of dying) on places of the body not requiring medical attention or just minor stabilization in an emergency room (Linehan et al., 2006; Simon, 2014).

Summary

Mental health issues among church leaders appear to be continual, causing 19% to resign. As shown in the examples of pastors who have died from suicide, their stories indicate more than a few considerations and intentionally end their lives. The suicidal clergy appears unable or unwilling to cope with living in a corrupt world. The fact that Christian church leaders are overly stressed but hide their internal struggles is apparent, as shown in the research. A few of the longest-running research ministries are (a) Christian Research Institute (CRI; 1960 to present), (b) BARNA (1984 to present), and (c) Lifeway Research (2006 to present). This group of research programs provides statistics and information on the state of pastors. Despite more public awareness and acceptance of mental health, mental illness still seems to be a stigma, and pastors with these issues do not believe there is help for themselves. This research shed light on church leaders' motivation for help-seeking behavior.

CHAPTER TWO: LITERATURE REVIEW

Overview

Research on various aspects of the Christian Church has been an ongoing endeavor for many years. Researchers have revealed that identifying as a believer and participating in religious activities, including being a leader, are not preventive actions for developing a mental health disorder. The first section discusses the theoretical framework underlying this research.

The second section explores related literature, including theories related to help-seeking behaviors. The following section reviews the research on mental illness and the help-seeking practices of professionals and people in general, secular, and church definitions of mental illness, church leaders' challenges, and the professional views on what helps those with mental illness.

Although the researcher reviewed other mental health and help-seeking aspects, this study did not focus on every one of these topics because the topic of mental health is too broad and descriptive. This study was also limited to leaders of the Christian faith, as studying different religions is more complicated, requiring extended hours and financial and team support (Clooney, 2018; Faber & Fonseca, 2014; Krech, 2012). Aside from this, not focusing strictly on one Christian denomination is because mental problems are universal, although psychological issues can manifest differently based on culture, gender, and age (APA, 2013). A depressed Baptist preacher is no different from a depressed Lutheran pastor. The differences can be in the two pastors' emotional states assessing the intensity, frequency, and duration of the depression. Still, the fact that they are depressed is not related directly to their Christian faith's denominational stance. Other religious studies use religiosity as a variable, but this is a general label, not specific to a denomination (Lukachko et al., 2015).

Theoretical Framework

Heidegger's Interpretative Phenomenological Philosophy

Martin Heidegger (1889-1976) originated the branch of phenomenology called hermeneutics. The simplest explanation of Heidegger's hermeneutic philosophy is the focus on "being" (Bever,

2014; Smith & Nizza, 2022). However, Heidegger's hermeneutical scheme is far from simple, and it is one of the most complex philosophical concepts for researchers to use in their studies (Bever, 2014, p. 2; TheGreatThinkers.org, n.d.). According to Heidegger, an accurate understanding of life is achieved through how individuals, couples, and families speak and interact within a socially interactive world system (Smith & Nizza, 2022). Heidegger believed that knowledge is only gained within "an interpretive stance while grounding this stance in the live world-the world of things, people, relationships and language" (Smith et al., 2009, p. 22). Heidegger's description of the existence of human beings is "Dasein," meaning "there-being," which entails "individual psychological processes, such as perception, awareness, and consciousness" (Smith et al., 2009, p. 22). A person's existence is interdependent and interconnected to the physical world and other people, with the ability to differentiate between objects in one's world (Bever, 2014; Smith & Nizza, 2022). Gadamer stated, "We are at once interpreting and making the story our own; understanding a story is to 'always and already' to understand and recognize ourselves within it" (Crowther et al., 2017, p. 827).

The "hermeneutic circle" is one of the critical aspects of this theory, "it is concerned with the dynamic relationship between the part and the whole at a series of levels" (Smith et al., 2009, p. 33). In the process of analyzing data, a researcher does not move in a straight line but tacks back and forth, starting and stopping at different points in the data, connecting ideas from different levels until arriving at a complete understanding of the whole sect (Smith & Nizza, 2022).

Related Literature

Theory of Planned Behavior

Ajzen (2005) stated that the theory of reasoned action/TPB "postulates that a person's intention to perform (or not perform) behavior is the most important immediate determinant of that action" (p. 118). Intention and behavior are dependent on three influential psychological paradigms, the person's "attitude toward the behavior . . . perception of social pressure to perform or not perform

the behavior under consideration (subjective norm) . . . and perceived behavioral control" (Ajzen, 2005, p. 118).

Rickwood and Thomas (2012) sought to clarify what factors contribute to the development of a "conceptual measurement framework for help-seeking" (p. 173). Rickwood and Thomas (2012) did not find a nationally recognized theory of help-seeking behavior. The concept of help-seeking appears simple, but research shows that help-seeking is a complex behavioral, psychological, and community resource interaction system (Rickwood & Thomas, 2012). Rickwood and Thomas (2012) created a "conceptual measurement framework," including these "essential elements": the part of the help-seeking process to be investigated and "the respective time frame, the source and type of assistance, and the type of mental health concern" (p. 173). Rickwood and Thomas proposed this general definition for help-seeking, "In the mental health context, help-seeking is an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern" (p. 180).

A limitation of TPB Is that environmental and emotional factors are not considered integral to human behavior (LaMorte, 2019). A society's culture is the lens through which understanding and applicability of healthcare paradigms are derived and applied in individuals' lives (Arnault, 2009).

Cultural Determinants of Help-Seeking

Arnault's CDHS theory is that people ask for help based on their cultural values regardless of their health condition. CDHS is comprised of "idioms of wellness or distress," defined as "a collection of physical, emotional and interpersonal sensations and experiences labeled by the individual as optimal or abnormal, and identified as important" (Arnault, 2009, p. 2). According to Arnault (2009), "signs of wellness" are positive feelings or body functioning, and "symptoms" are the negative, unhealthy emotional and physical states, both of which are determined by the cultural perspective (p. 4).

Culture divides into four interrelated dimensions: cultural ideology, political/economic, practice, and body (Arnault, 2009, p. 3). Arnault (2009) stated that cultural ideology is the moral

compass most of society holds. Artistic thinking shapes culture's political and economic parts, which are the guidelines for allocating wealth, power, work, and social behavior policing. According to Arnault (2009), "The [practice of culture] includes both power and ideals—these two forces are acted out in even the smallest gestures, speech patterns, manners of dress, social distances, food choices, and health behaviors" (p. 3). Individuals do not exist outside of their culture. The person's inner being is interwoven with the external processes of their specific society prescribed by the cultural model providing "specific and consensual guidelines about ideals, values, motivation, goals, social roles and preferred social behaviors" (Arnault, 2009, p. 3). Some churches' cultural belief, that mental illness is caused strictly by supernatural or demonic forces, is a form of "causal attribution." The church defines mental illness and what to do about it (Arnault, 2009, p. 4). A person's social connections are an integrative influence on a person's mental and physical health (Arnault, 2009, p. 5). The quality of these relationships has a direct impact on how a person evaluates their psychological or physical condition, and "symptoms of distress or illness can be interpreted as indicating signs of moral weakness, physical frailty, or failure to carry out critical social roles" (Arnault, 2009, p. 5). Church members' judgment could be why church leaders with signs of mental distress do not admit this to their congregations or seek help for fear of a negative social outcome (Arnault, 2009). While there was little literature about church leaders with mental illness help-seeking behavior, there were several studies on help-seeking, mental health, and different aspects of church leadership. Reviewing this literature helped give this researcher insight into the topics relevant to this study.

Past Research on Mental Health Seeking Behaviors

Help-Seeking Behavior in Other Professions and the General Population

Asking for help with mental health issues is a critical step in healing, but people struggle through the stages of help-seeking, from what they believe about the problem to what they intend to do about it. Seligman and Reichenberg (2014) showed that clients with better treatment outcomes are

motivated for treatment, have a realistic understanding of what therapy can and cannot do to help them with their problems, and are active participants in the therapeutic process.

Community Help-Seeking

One qualitative study used community-based participatory action with grounded theory to identify what prevented people with severe mental and substance abuse issues from receiving professional assistance. Ross et al. (2015) obtained a sample from advertisements at local organizations. The researchers surveyed 85 adults and 17 service providers using semi-structured interviews. The interviews' results classified two client-level factors identified as treatment barriers: socioeconomic and mental health experiences (Ross et al., 2015, p. 4). Provider-level factors are "their knowledge of mental health and substance use, their willingness to address these issues in their practice, and their values and attitudes and ability to be caring and emphatic as it relates to mental and substance abuse issues" (Ross et al., 2015, p. 13). Ross et al. primarily identified external barriers to help-seeking within a sample of economically challenged people.

In another WHO study about mental health and help-seeking, using multistage probability sampling, Andrade et al. (2014) surveyed a large multi-cultural sample (N = 63,678). The factor most identified with not seeking assistance for psychiatric problems was not external, as Ross et al. (2015) reported. The issue most likely linked to not seeking mental help was internal, the belief that a person does not need help for their mental issues (Andrade et al., 2014). In a similar 2015 project, Umubyeyi et al. reported that self-efficacy is the most significant barrier to mood disorder treatment.

Professional Help-Seeking

Professionals, no matter the field, are held to a stable self-image, and the public imposes a higher standard for being internally secure. Edwards and Crisp (2017) performed a quantitative survey of 67 active mental health providers; 31 were clinicians in training to assess help-seeking behavior. The participants completed an online questionnaire comprised of questions from the Barriers to Access Care Evaluation scale. Results were in line with the other studies discussed

(Andrade et al., 2014); these mental health professionals did not seek help, even though they may have needed it, because they believed they could manage it themselves (Edwards & Crisp, 2017).

In another quantitative study, Gold et al. (2016) questioned what keeps depressed, female medical doctors and psychiatrists from seeking assistance. Gold et al. (2016) created a 24-question questionnaire. Gold et al. (2016) assessed 2106 completed surveys. Regarding help-seeking, nearly half of the participants did not seek mental health treatment for fear of stigma, jeopardizing their license, and believing in self-healing (Gold et al., 2016, p. 51).

Furthermore, Clough et al. (2019) wanted to answer the same question as Gold et al. (2016): Medical providers are under a great deal of pressure, but when it becomes too much, what are they doing about it? Clough et al. employed a mixed-methods study, using a quantitative survey of 274 Australian-based medical doctors and a subset of 20 completed qualitative interviews. However, despite several barriers to mental health care, including external factors such as lack of availability, the most identified reason for doctors not seeking help was insufficient time (Clough et al., 2019).

Those in the helping professions are overworked with high caseloads and little time for relaxation and recovery (Jackson-Jordan, 2013), leading to burnout, substance abuse, mental disorders, and social and vocational problems (BARNA, 2017; Clough et al., 2019; Jackson-Jordan, 2013). Christian leaders reported that advanced spirituality might prevent them from seeing negative internal mental health symptoms as a secular psychological problem (Salwen et al., 2017).

Issues Commonly Dealt with By Church Leaders

Mental Health Symptoms

A message found in leadership books and church leadership manuals is that they are supposed to be mentally healthy and able to handle their "calling from God," as shown here in this statement by Farr and Kotan (2016):

> We need confident, competent leaders in the church! We do not need arrogant leaders in the church. We do not need more non-reflective leaders or leaders lacking self-awareness in the

> church. I am sure that the Apostle Paul sometimes struggled with his balance of confidence and arrogance. But it was worth the risk. .....Paul was a confident leader. Today, we learned that confident leaders are not afraid to be coached, to be in a continuous learning group, to have a mentor, and to be in constant modes of connection, questioning, and seeking best practices (p. 36).

There are no words of comfort and direction for the church leader who struggles with depression and feelings of inadequacy. The lack of comfort and direction could explain why many do not speak to their peers or congregations about their psychological problems. Those in helping professions need preparation to influence the mental health that counseling troubled people produces (Sanders, 2017). Church leaders who are not internally secure and are isolated and untrained to deal with complex problems are not an excellent help to others (Chavez, 2021).

Finding journal articles about "depressed or mentally ill pastors" is complicated because search engines often return results about pastors treating people for depression, not pastors with depression. For example, Payne (2013) studied how a clergy member's educational and religious training impacts the decision to refer depressed clients to a secular therapist; this was the second article listed in a Google Scholar search for "depressed pastors." Another study about pastors with depression was a commentary by Pietsch (2011). However, it was a discourse about a letter written by Martin Luther in the 1500s addressed to George Spalatin. Reportedly, Luther tried to comfort a depressed Spalatin by telling him about his own problems with severe hopelessness.

More recent research by BARNA (2017) reported they are "dismayed to learn how many [pastors] are struggling . . . and weighed down by depression ..... and isolation" and that 25% are dealing with emotional issues (pp. 6, 11). Other studies have shown similar results, such as Miles et al.'s (2011) quantitative analysis to identify differences between rural/non-rural United Methodist pastors' healthy lifestyles. Miles et al. (2011) assessed 571 rural and 942 non-rural pastors using 3 measures. The one for mental symptoms was HADS. Miles et al. (2011) did not explore the mental

health results further because the study compared rural and non-rural pastors. The results for the HADS were similar for rural and non-rural pastors (Miles et al., 2011, p. 18). However, the combined ratio of rural/non-rural showed that 19% tested positive for psychiatric symptoms.

The concept of burnout is discussed further in a separate section of this dissertation. Francis et al. (2017) performed a similar study with the independent variable of burnout to confirm the reliability of the Francis Burnout Inventory compared to the SIBS for assessing pastors. Francis et al. (2017) posited that emotional exhaustion and satisfaction in ministry mediate the burnout level. Francis et al. (2017) assessed a sample of 658 Church of England clergy with the Scale of Emotional Exhaustion in Ministry and Satisfaction in Ministry Scale (SIMS; p. 10). Of Francis et al.'s (2017) pastors, 26% tested positive for depression.

Notably, BARNA based their report on 25% of pastors having mental challenges on compiled data from 2006 to 2016 with a sample size of 14,033. Compared with national statistics on adult depression from 2013-2016, Brody et al. (2018) indicated that 8.1% of general adults had a depressive episode based on data from an estimated sample size of 50,000+ (p. 1). Doolittle (2015) also found the same statistics indicating high rates of depression for pastors. Although the results from BARNA, Brody, and Doolittle had different sample sizes, pastors may be depressed more than the general population.

Burnout

Many reports have discussed that numerous church leaders worldwide, particularly pastors, feel overwhelmed and depleted of internal resources for dealing with life and occupational stress. Over half of practicing leaders, regardless of denomination, were overly stressed, leading many to abandon their calling (Jackson-Jordan, 2013; Tunnell, 2020; Visker et al., 2016). Halloran (2013) reported, "1,500 pastors leave the ministry each month due to moral failure, spiritual burnout, or [church conflicts], and 80% of [religiously trained and educated will abandon] the ministry within the first five years" (para. 9). Fox (2014) stated working with complex behavioral presentations elicits

reactions from the helper. A church leader not experienced in dealing with transference issues negatively impacts the relationship and leads to "burnout, ethical violations, or worse" (pp. 3-4).

Compassion fatigue is linked to ministry burnout, making it difficult for those who help others to help themselves. Years of feeling unsupported and overworked, combined with the vicarious experience of dealing with other people's complex problems, can deplete a helper's desire to assist others. Compassion fatigue resembles diagnosable mental disorders, according to Figley (2002), who stated, "compassion fatigue, like any other kind of fatigue, reduces our capacity or our interest in bearing the suffering of others" (p. 1434). Church leaders who engage in poor self-preservation link to burnout and compassion fatigue, and researchers show that church leaders are known for neglecting self-preservation activities (Jones, 2018; Newell & Nelson-Gardell, 2014; Snelgar et al., 2017).

Training Inadequacies

Extensive training, education, religion, and experience are not preventive factors for psychiatric disorders. For example, doctors and nurses are just as stressed as the patients they treat, and these professionals are less likely to seek help (Clough et al., 2019; Savage et al., 2016). The lack of training about other situations beyond biblical knowledge contributes to church leader stress. Twenty-three years ago, researchers indicated the inadequate preparation of church leaders to deal with the varied and complex problems presented by people. However, despite all the technological and social advances years later, nothing has changed (Adams et al., 2017). Results from several studies indicate the expanding belief that Christian ministers need additional advanced training and education in psychosocial issues (Aramouny et al., 2020; Jackson, 2014; Jang et al., 2017). Helping professionals should know their strengths and limitations. It should only work with clients with the correct clinical and educational training to treat and know when to refer clients with issues outside our clinical expertise (Seligman & Reichenberg, 2014). This study was not generalizable due to the small sample. This qualitative study of the mental health beliefs of the Korean Christian clergy had an

exciting finding. Most participants obtained education on mental illness. Most thought they knew enough about mental illness to identify depression in examples, yet over one-third failed to correctly identify depression in the clinical samples (Jang et al., 2017). Many ministers lacked training from their religious schools to deal with mental illness and the complex problems people have; as one rabbi stated, "No one learns about this in rabbinical school..... rabbis are both the wounded and the healers" (Crary, 2020, para. 27).

Lack of Support

Two are better than one is a foundation of human social functioning. Helpers need help with knowing whom to turn to when they need assistance. According to Gillard et al. (2014), mental healing is predicated on trusting and productive relationships. Those in the helping professions and church leaders are particularly known for being isolated with little support beyond their immediate families (Kinnaman et al., 2017; Koenig, 2018). Scott and Lovell (2015) completed an intervention for a small group of rural pastors and found that "though participants know they have a support system, they tend to not tap into it to engage in self-care" (p. 92). At least half of pastors are not getting the support they need (Halloran, 2013). In a study of 261 Seventh-day Adventist pastors, Heck et al. (2018) identified poor support as the most significant problem for this sample of participants.

In 2017, BARNA reported that most clergy members need more help from their church and community (p. 10). Although Van Orden et al. (2014) focused on adults aged 60 and older with a small sample $N = 124$, the results were fascinating. Van Orden et al. (2014) studied the effects of a 16-week treatment intervention comprised of psychiatric medications and interpersonal psychotherapy (IPT) for older adults diagnosed with unipolar depression. Van Orden et al. (2014) randomly assigned the participants to different control groups. Van Orden et al.'s (2014) hypothesis was that social disconnectedness links to severe psychiatric issues, including suicidal tendencies. Van Orden et al. (2014) reported that social connections combined with mental health treatment might influence depressed and suicidal adults, but the results were insignificant. Another issue with poor

support is compassion fatigue; this increases the minister's likelihood of leaving the profession (Spencer et al., 2012). There are several reasons church leaders may have social issues and are isolated, which are discussed further in this study.

Stigma

Stigma against mental illness, real or self-imposed, is a problem within professional communities. In a mental illness study in the armed forces and different forms of stigma, Coleman et al. (2017) found five factors linked to shame and help-seeking behavior: (a) non-disclosure, (b) individual beliefs about mental health, (c) anticipated and personal experience of stigma, (d) career concerns, and (e) factors influencing stigma. Other research has found these points on stigma and mental health.

Non-disclosure

African American Christian congregations tend to suppress and are unwilling to disclose psychiatric issues, as seen by one Black church member's statement, "I don't put my business out in the street..... What if they think I'm crazy?" (Armstrong, 2016, p. 119). Fear of being discovered with a mental illness still causes those suffering to keep their struggle to themselves. Unfortunately, pastors who have opened up to family or church have met with disbelief, judgementalism, rejection, or shaming (Clement et al., 2015, p. 24). Non-disclosure is one of the most identified factors linked to stigma, but hiding their issue does nothing to alleviate the inner torment (Lasalvia et al., 2012; Vilhauer, 2017). The 32 Black and White clergy participants in Campbell's (2021) qualitative study revealed the ongoing problem that stigma keeps people from revealing their issues and seeking help for mental issues. Other factors related to non-disclosure of psychiatric problems include not wanting to be shunned by one's community, family, or coworkers (Brohan et al., 2011). Churches are known for rejecting members who do not align with that congregation's ideals (McGinnis, 2015).

Individual Beliefs About Mental Health

Personal beliefs shape the way a person's life functions. How a person thinks about psychiatric concerns and stigma returns to civilization's beginning (Plante, 2013). Communities excluded those who demonstrated behaviors and ideas contrary to that community's social norms (Plante, 2013, p. 8). Those deemed not psychologically sound would have their legal personal responsibility rights taken away by court systems (Corrigan et al., 2015; Plante, 2013, pp. 8, 12, 34). Individuals with mental issues are seen as somehow responsible for their illness or intellectually challenged (Lucksted & Drapalski, 2015; Parcesepe & Cabassa, 2013).

Another perpetuated misrepresented belief is that people with mental illness are violent despite studies showing that approximately 96% of psychiatric persons do not engage in violent behavior (Varshney et al., 2016, p. 223). More recent research indicates that aggressive mentally ill persons are 1 to 5% of the population (Ahonen, 2019).

Anticipated and Personal Experience of Stigma

Drapalski et al. (2013) examined the link between self-perceived stigma and the beliefs contributing to the patient's confidence and trust in their primary general doctor's ability to help. The research is a mixed-method exploration of 100 participants with different psychiatric problems and how internalized stigma impacts diagnosis. The fear of being judged incorrectly was a primary reason for not looking for assistance for psychological trouble. Although the homogenous African American sample did not allow for generalizability, the results showed that internalized stigma is detrimental to maintaining a healthy lifestyle. Gender is another essential variable that could relate to church leaders' help-seeking behavior, as most leaders tend to be men (Rayburn, 2015). Another study of men with mental illness found self-stigma as a dependent variable for non-help-seeking behavior (Cole & Ingram, 2020).

Self-stigma is a commonly identified issue for people with psychiatric problems. According to Or et al. (2013), self-stigma occurs when a person internalizes the "negative social stereotypes that

society relates to mental illness," and mental illness is judged as a personal failure (p. 196). In Brohan et al.'s (2011) study of 1182 persons, 21.7% with bipolar or depression reported self-stigma (p. 56). Those in leadership positions experienced more pressure to uphold a stable persona, but repeated disappointments combined with excessive work hours could contribute to feelings of depression and inadequacy (Grohol, 2018; Johnson, 2016, p. 3). In a 2015 online survey of 275 pastors, 60% felt overworked, 53% struggled with depression, and 60% doubted the calling to minister (Lane, 2015).

Career Concerns

More than half of pastors have struggled with chronic depression and discouragement and felt trapped in their ministry role with no other job skills (Lane, 2015, para. 8). Lovett (2020) stated, "in most industries, federal laws protect workers with disabilities, including mental illness. Church is the exception" (para. 1). According to Lovett (2020), talking about their mental issues has cost pastors their jobs (para. 1). Several studies show workers with mental illness fear and face stigmatizing actions in their careers. According to Thornicroft et al. (2009), one-third of 732 persons with schizophrenia who were looking for jobs feared the stigma that never occurred. One consequence of stigma in working situations is the prevention of advancements and new job roles (Krupa et al., 2009). Also, a worker's competence and performance may be questioned (Elraz, 2018). A person's professional reputation is at risk of tarnishing due to being identified with a mental illness (Picco et al., 2019). A pastor may be reluctant to reveal any psychological issues for fear of how their image will be judged, given that some churches still view psychiatric problems as demonic (Mercer, 2013). In a survey by Lifeway (2015) of 1500 U.S. pastors, 90% have taken actions to "protect their image as a pastor" (p. 14). Today, a person's public reputation can impact one's psychological functioning.

Factors Influencing Stigma

A few areas address the stigma and its influence on people seeking mental assistance (Coleman et al., 2017, p. 1887). People are more likely to seek help when they support colleagues, supervisors, and coworkers (Coleman et al., 2017, p. 1887). Some clergy members have feelings of

extreme loneliness, not believing they have anyone to turn to, including other preachers (BARNA, 2017; Johnson, 2016, p. 3; Lane, 2015).

Another significant factor for eliminating the negative influence of stigma identified by Coleman et al. (2017) is mental health education. Other studies have produced data suggesting that educating the public about psychiatric information improves people's understanding and demystifies myths asserted toward mental health clients (Kutcher et al., 2016). Contrarily, Durand-Zaleski et al.'s (2012) survey of 1000 adults in France reported that general anti-stigma campaigns were ineffective at changing people's assumptions about mental illness.

Church Culture

Although the Christian church strived to be involved in early mental health studies, the church has a mixed response. The 16th-century Catholic church viewed anything related to a psychiatric nature as "sin, demonism, and madness" (Fabrega, 1991, p. 101). *Christian* and *church* are umbrella terms for many independent denominations with similar and different core beliefs and religious practices. However, one common theme found among them, according to research, is that despite societal advances and an increase in public awareness of the reality of mental health, churches, by and large, still hold negative beliefs about anything to do with psychiatric illness (Scott & Bergin, 2014, p. 476). Vacek (2015) stated that the fear of association had kept the Protestant church from connecting with its mentally ill parishioners (p. 3). Wong et al. (2018) found a different response among religious communities, as about one-third of the religious congregations surveyed provided mental health services. Church members are known to reject those within their groups who do not conform to that sect's ordinances (McGinnis, 2015). Flaten stated, "I discovered the double standard: We may be willing to minister to persons with mental illnesses, but we can't have them among us, the clergy!" (Kristula, 2008, p. 33). Their congregations support pastors differently. For example, one is providing a salary; however, this can be a source of stress, as ministers are entirely dependent on the

church for financial support, making them susceptible to the desires of the congregations, even when the pastor disagrees (Noel & Due, 2018).

The Isolation of Church Leaders

When a young man or woman enters seminary or some other training/education to become a pastor/minister/reverend/clergy, they start with naïve expectations. Hilgemann (2019) expounded on 20 conflictual consequences of being a pastor that he did not know he would experience before taking the position. “I wish someone would have sat down and told 20-year-old me,” stated Hilgemann about the challenges he would face, one of which was depression. One-third of pastors surveyed by Lifeway (2015) reported feeling secluded from others. Several web pages cited the statistic that 70% of pastors feel lonely; however, the listing of the research where this statistic came from was missing in most of the articles (Florida Baptist Convention Administration, 2019; Gaultiere, n.d.; Hagen, 2015; Stand Strong Ministries, n.d.; Wagner, 2018). BARNA’s (2018) research showed that 38% of pastors are isolated.

Scott and Lovell (2015) found loneliness and isolation significant issues among 51 rural pastors and implemented an 18-month intervention to help these church leaders overcome their inner and outer stabilization barriers. The results of this study seemed to have effectively improved this group of pastors’ mental and social functioning but did not impact their self-care actions. Scott and Lovell (2015) believed a pastor’s self-reliance and view of self-care as a luxury prevent miners from taking self-care steps.

Preventive Factors

Empathy

Nouwen (1979) discussed how ministers could successfully use their suffering to help others without becoming consumed by internal struggles; empathy is that factor that keeps leaders grounded. Assisting suffering people requires different skills and an appropriately managed empathetic demeanor. Compassion and caring for others in a non-judgmental, unselfish, and vicarious manner

are crucial to maintaining a stable mindset. Insight can motivate caregiving, but empathy without protective mental and spiritual boundaries can be a means of burnout (Hunsaker et al., 2015; Lamothe et al., 2018). After reviewing studies on physicians' patient interactions, Thirioux et al. (2016) reported that empathy is a common component of self and other wellness.

Ethical and Moral Values

Researchers dispute whether spiritual or religious beliefs and activities are helpful for overall stable mental health. The quality of a ministry leader's relationship with God is the key to interpersonal functioning (An et al., 2019; Ruffing et al., 2018). In more recent research, Salwen et al. (2017) did not find that spirituality impacted help-seeking or mental health for seminary students. The dispute is whether this is true for other church leaders because another study reported that religious activities do appear to have a practical impact on mental stability (Isacco et al., 2016). However, both studies had small and homogeneous population samples making the inference to the general public untenable. Other research showed the paradoxical influence of spirituality, as stated by Koenig (2010), "While spiritual beliefs often represent potent sources of comfort, hope, meaning, at times they can be entangled with mental and emotional disorders making it difficult to determine whether they are a resource or a liability" (p. 116). Still, in his current study, Koenig (2018) listed nine reasons religious beliefs help deal with life problems and mental illness: (a) an optimistic worldview, (b) a purpose-driven life, (c) an acceptive perspective of the challenges caused by the ordinary trials of life, (d) hopeful future orientation, (e) empowering coping behaviors, (f) internal self-control, (g) role models who deal with suffering and instructions for coping with tragic issues, and (h) self-actualization. The following discussion further examines a few of Koenig's nine reasons related to depressed and suicidal clergy.

Acceptive Perspective of Challenges

The world is conflicted; between global conflicts, dysfunctional and broken families, prolific diseases, and other problems, maintaining a realistic outlook on life can be challenging. The

instruction of Christians is to have a different and even positive perspective about the everyday trials one suffers being alive in a corrupt world (James 1:2-4; Philippians 4:12-13; Romans 5:3-5, 8:17-18). In 1982, Steven Hayes created acceptance and commitment therapy (ACT), a somewhat complicated form of cognitive-behavioral treatment (Hayes et al., 2011). ACT intends to help clients improve their "psychological flexibility" (Hayes et al., 2011, p. 65) by the cognitive defusion of "negative thinking and unnecessary emotional dwelling" (Miguel, 2019, para. 2). Cognitive defusion is the ability to see thoughts as just thoughts, regardless of the view (Hayes et al., 2011). To diffuse, one does not try to change the way one thinks or feels; instead, they accept the thoughts and feelings as usual processes, and what a person does with the content of the biological/mental messages is up to the person (Hayes et al., 2011, p. 24). Hayes et al. posited that people's significant problem is avoiding unpleasant experiences, often leading to unhealthy behaviors. Another important aspect of ACT is "cognitive fusion," when the contents of a person's thoughts are believed more than what is right (Hayes et al., 2011, p. 20). According to Hayes et al. (2011), "People whose cognitions fuse are likely to ignore direct experience and become relatively oblivious to environmental influences . . . it is as though they are imprisoned by the rules originating in their mind" (p. 20). Cognitive fusion could be the process in pastors' minds when they become depressed and suicidal.

Hopeful Future Orientation

Profession Christians are supposed to have hope in the present and future as a quality (2 Corinthians 4:18; Proverbs 23:18; Psalm 147:11; Romans 12:12, 15:4). Unfortunately, hopelessness is a fundamental emotion reported by suicidal people and identified with major depressive disorder (APA, 2013). This study did not focus on what causes so many church leaders' misery, but hope was discussed here as a component for severe mental illness and suicide prevention. Sadeghi et al. (2015) tested the effectiveness of "hope therapy" through 8 group sessions for 25 adults. Sadeghi et al.'s (2015) study participants were previously diagnosed with a mental and substance use disorder. The participants who completed the program reported improved scores on the Hope Scale, along with

"reduced depression symptoms" (Sadeghi et al., 2015, p. 4). In another group study of 50 stressed and depressed dialysis patients, those who completed hope therapy had a significant post-month improvement in psychiatric scale scores (Rahimipour et al., 2015). Drug addicts are known to struggle with hopelessness about staying sober, so Sadeghi et al. (2015) wanted to determine if hope therapy could help 25 clients diagnosed with methamphetamine and depressive disorders. After eight sessions, hope therapy positively affected the participants (Sadeghi et al., 2015). Hope is not just an emotion or thought process; hope is an active and intentional system of actions one takes to overcome life challenges (Lopez et al., 2000).

Empowering Coping Behaviors

How does one cope with the severe problems one can face today? Coping strategies are a well-researched topic. In their book *Coping skills for a stressful world*, Muratori and Haynes (2020) acknowledged that although external, uncontrollable situations cause much stress, several problems result from a person's unhealthy self-inflicted actions. Helping professionals have various coping strategies, but these skills are not used regularly, making them inaccessible during a crisis (Muratori & Haynes, 2020). Maladaptive psychiatric conditions link to avoidant coping strategies (Chiles et al., 2018; Kim et al., 2012). The classification of avoidant coping is as "passive [actions] such as ventilating distress, withdraw[ing] and isolat[ing], relying on others to change, and or hoping the problem will resolve itself over time without any action" (Chiles et al., 2018, p. 72). In their study of what client factors contribute to therapeutic effectiveness for 60 Asian and White American psychiatric clients, avoidant coping exacerbated emotional issues (Kim et al., 2012). In another study of 439 depressed adolescents, depression and suicide possibly linked to negative coping, but more longitudinal research is needed to confirm causality (Becker-Weidman et al., 2010).

Life adaptation skills may help people with mental health issues. In Chen et al.'s (2015) study of 68 clients, the 33 who received the adaptation intervention had lower scores for anxiety and suicidal ideation (p. 108). In another investigation of how coping skills help alleviate irritable bowel

symptoms (IBS) for 95 clients, Torkzadeh et al. (2019) reported a significant influence of the quality of strategies on psychiatric and medical symptoms. The clergy is one of the occupations in Bertram et al.'s (2001) study of patients with chronic IBS stress-impacted symptoms. According to Bertram et al., engaging in social support groups is an effective way to cope with IBS clients.

One form of church leader coping strategy is "spiritual practices" (BARNA, 2017). According to BARNA (2017), pastors at higher risk of burning out combined with low social functioning "put themselves at higher risk when it comes to stress and relationship health" when they do not "make time for spiritual development" (p. 27). Prayer and Bible study are pastors' two most identified spiritual practices (BARNA, 2017; Fee, 2018; Worthington et al., 2014). McLean (2015) stated "an essential component of spiritual practices" is to "understand [his] humanity, connection with others, and [his] relationship with the divine" (p. 203).

Internal Self-control

According to Proverbs (*English Standard Bible*, 2001, 25:28), "A man without self-control is like a city broken into and left without walls" (p. 909). People spend thousands of dollars and uncountable hours trying to gain self-mastery in various areas but controlling one's mind and emotions is the most sought-after but elusive skill (Duckworth et al., 2016; Friese et al., 2017). Lack of self-control is a source of many problems, including self-harm behaviors and various addictions (Vohs & Baumeister, 2016). According to BARNA (2017), most "pastors are personally content and spiritually motivated toward growth and transformation" (p. 10).

Bonelli and Koenig's (2013) review of 43 research articles concluded that religious and spiritual beliefs and actions support mental health. Bussing et al. (2016) had an adequate sample size of Roman Catholic leaders ($N = 7390$). The depth and quality of a religious worker's relationship and communication with God through prayer appear to be protective factors for mental disorders (Bussing et al.). Hackney and Sanders's (2003) analysis of 35 studies about religiosity and psychiatric health reported that religiosity positively correlates to positive mental well-being. Nonnemaker et

al.'s (2003) review of data from a longitudinal investigation with a large sample size (*N* = 16,306 adolescents in grades 7 to 12) indicated that the quality of personal religious beliefs and prayer life had a positive influence on preventing self-harm thoughts and behaviors (p. 2053).

Religious activities may not protect against developing a mental illness; instead, religiosity can contribute to psychological problems (Parament & Lomax, 2013; Williams & Faulconer, 1994). However, spiritual practices can help alleviate the intensity of psychiatric symptoms (Feinson & Meir, 2015; Harris et al., 2015; Starnino & Sullivan, 2017). Whether spirituality helps with mental problems depends primarily on the person's perspective of suffering from this issue (Oxhandler et al., 2018).

Resilience and Humility

Pride and a lack of understanding and empathy toward hurting people can contribute to a church leader's mental stability. A sense of pastoral superiority can negatively impact their work with sensitive topics (Glanville & Dryer, 2013). According to BARNA (2017), "Those who are humble . . . are not threatened by intellectual disagreements, are not overconfident in their knowledge, have respect for others' viewpoints, and are open to revising their views" (p. 52). Resilience is a personal ability to overcome adversities (Connor & Davidson, 2003). Resilience is a form of coping with internal and external emotional processes (Capstick, 2018). Employing a sample of 37 mental health therapists, Pereira et al. (2017) used the Connor-Davidson Resilience Scale and Mindful Attention Awareness Scale to measure resilience and mindfulness related to treatment outcomes. Pereira et al. (2017) reported qualities held by successful professional counselors.

Communication Skills

Church leaders must have "deep listening skills" to successfully listen objectively and introspectively to deal with internal emotional or psychological reactions triggered by the client's stories (Parameshwaran, 2015, para. 4). Although Lount and Hargie (1997) found that advanced communication and counseling abilities are critical skills for a minister's work with others, the

researchers did not state how a deficit in these areas would impact the priest's functioning. The study results now identify poor communication as linked to mental illness and death (Kaufman et al., 2012; Latoo et al., 2013).

Understanding Boundaries and Limitations

Church leaders yield much control over their congregations and prevent burnout and mental distress, and they need to have clearly defined and implemented boundaries. One of the most significant concerns related to pastoral boundaries is stepping outside their borders to engage in illicit and often abusive relationships with other adults, including children (Langberg, 2020; Ormerod & Ormerod, 2018). Although abusive and unfaithful preachers are not the focus of this study, these actions are interconnected; child abuse and adultery charges precede several of the pastors' suicides.

According to Skovholt and Trotter-Mathison (2016), being overcommitted has its downfalls, so counselors need to understand the stage of change their clients are in or risk disrupting the therapeutic alliance. Over half of the pastors are providing counseling services (Stetzer, 2018; VanderWaal et al., 2012), and Schulze (2007) thought that mental health workers have reduced "professional boundaries" (p. 145). Professional boundaries involve "place, space, time . . . [clergy's role] and client's [parishioner's] rights, [mutually agreed-upon behavioral expectations], and [ethical standards] as they related to influential power and legitimated power" (Haug, 1999, p. 412). Pastors who do not have assertive boundaries are more at risk for burnout (BARNA, 2017).

Place, Space, and Clergy Role

Pastors operate in different physical locations, from the church building to other church-related settings and homes. When it comes to time, ministers must juggle time at home with family and church. Pastors spend an inordinate amount of time doing things outside of church and family duties (Hough et al., 2019). Many church leaders hold various positions aside from the pastor. Aside from providing counseling services, some serve as community board members and other multiple activities (Proeschold-Bell et al., 2013). Most counseling-related licenses have an ethical standard

where the counselor only works with the expertise for which they are trained and qualified. Pastors often provide therapy without formal training and are reluctant to refer to professional counselors (Banschick, 2015; McCain, 2017; Smietana, 2014).

Client/Parishioner Rights

Understanding one's boundaries for how involved a pastor is in another person's life relates to the pastor's abuse of their power and authority and interference with their congregation's lives. Clients/parishioners may not understand the "power dynamics" between the leader and layperson, which can lead to "potentially negative consequences" related to the violation of "professional boundaries" (Haug, 1999, p. 412). Clients/parishioners need to understand their rights regarding what actions their minister wants to take in their lives, such as home visits (Haug, 1999). If a clergy member shows up at the home of one of their congregants, they may feel obligated to allow the pastor into their home, whether the visit is warranted (Haug, 1999).

Mutually Agreed-upon Behavioral Expectations

According to BARNA (2017), pastors controlled by their congregations are more susceptible to stress, depression, and burnout. Parishioners are known to have unrealistic expectations of their ministers, and if pastors do not establish firm boundaries, this leads to conflicts and "unhealthy church dynamics" (Proeschold-Bell et al., 2009, para. 9).

Proeschold-Bell et al. (2009) used focus groups of 59 United Methodist Church (UMC) clergy and 29 UMC district superintendents to explore health-related topics. Proeschold-Bell et al. (2009) identified a "congregational-level set of expectations" that influence the lack of a pastor's boundary setting but hold clergy accountable for being more assertive in boundary setting/enforcement rather than self-deprecating people-pleasers (p. 709).

Stable Support

As discussed earlier, lack of support is a problem many ministers deal with in today's increasingly stressful society. BARNA (2017) stated, "The vast majority of pastors are personally

content and spiritually motivated toward growth and transformation-yet almost every pastor needs greater support in some way from the community of faith" (p. 10). Social support is an identified, crucial component of mental stability. Glanz et al. (2015) divided social help into structural and functional categories (p. 184). The structural part of social support is the social networks of an individual's connection to family, friends, community, and other activities/relationships (Glanz et al., 2015). Social integration is how involved a person is in their social network, and the functional aspect is how good the actual or perceived support is (Glanz et al., 2015). Problems can be either in the social structure (poor connections) or the relationship's quality. Of BARNA's (2017) sample of Protestant pastors, 68% believed they had excellent structural and functional social supports; the problem came for those who had high-risk factors (i.e., burnout, relationship, and spiritual risks), where the quality of support seemed lacking the most. As mentioned earlier in Heck et al.'s (2018) sample of Seventh-day Adventist pastors, the pastor's stress level is connected to low social structure and lack of social functioning.

Secular Views of Mental Health Disorders

Physical

Daskalakis et al. (2013) suggested that resiliency is predicated on an individual's genetic code when exposed to a traumatic event. The way the brain reacts to stressful events is a process a person cannot control. Resilience to overcome overwhelming stress changes a person's thinking, but researchers must consider their physiological makeup. The brain's changes caused by trauma are essential for people who have experienced severe traumatic events, leading to psychiatric symptoms and disorders. Depression is a commonly identified problem in patients with heart disease (Dai et al., 2019; Wilkowska et al., 2019). Mental issues exacerbate medical matters, including the risk of mortality (AbuRuz, 2019). Gunathilaka et al. (2019) tested a random sample of hospitalized adult patients with various medical concerns for psychiatric symptoms ($N = 148$). Although the results showed that most patients had mental and emotional issues, patients with gastrointestinal problems

had the most intense anxiety (Gunathilaka et al., 2019). Gunathilaka et al. acknowledged the inability to make a definitive cause/effect statement about the patient's mental and medical health symptoms due to unverifiable variables.

Emotional

Emotions are a natural part of being human. Emotions give life meaning, but the scientific community debates emotions. Secular scientists Albert Ellis (1957), founder of rational emotive behavior therapy (REBT), and Aaron Beck (1976), founder of cognitive behavioral therapy, believed that emotional issues were a product of faulty thinking (David et al., 2018). Borchard (2018) reported their belief that depression is a symptom of problems in the brain, specifically "alterations of functional connectivity brain networks" (as cited in Brakowski et al., 2017, p. 147). Wainwright and Galae (2013) reported that a "reduced hippocampus" causes depression (p. 3). Chiba et al. (2012) reported "changes in the glucocorticoid receptor and prefrontal cortex" causes emotional issues (p. 112) as did McKlveen et al. (2013). The commonly classified emotions that can become problematic in people's lives are depression, anxiety, fear, and guilt. Nearly every mental health, substance use, and personality disorder diagnosis in the DSM-5 (APA, 2013) has an emotional component. A person cannot have a mental illness without the accompanying psychological symptomology. An overarching scientific label of emotional problems is "affective instability," although this title's understanding differs depending on the studied topic (Marwaha et al., 2014, p. 1793).

Cognitive

Cognitive is a catchall term for different forms of the human thought process or psychological well-being (Duckworth & Yeager, 2015; Pereira et al., 2017). This study defined cognitive problems as distorted and irrational thoughts, perceptions, ideas, and beliefs that negatively impact a person's behavioral and relational functioning (Mennin et al., 2013).

According to Eskin (2012), "the way an individual perceives a problem situation is more important than the situation itself" (p. 13). According to Ellis, thoughts are "irrational" if they "distort

reality, [are] illogical, prevent people from reaching [their goals], lead to unhealthy emotions and or self-defeating behavior" (Ross, 2006, para. 1). In REBT, Ellis classified what he called 12 irrational beliefs: (a) an adult needs love, (b) people are wicked and should be punished, and (c) it is terrible and catastrophic when things are not the way one wants them to be, (d) external events and people cause human unhappiness, (e) one should be terrified about potentially dangerous things, (f) it is easier to avoid than face life difficulties and self-responsibilities, (g) one needs something or someone more reliable, (h) one should be perfect, (i) one cannot heal from past hurts, (j) one's existence is dependent on others so one must do anything to make others change the way one would like them, (k) one does not have to do anything, happiness comes naturally, (l) one has no control over whichever emotions may come (Joshi & Phadke, 2018, pp. 32-33). Another list of four REBT irrational belief categories cited to have been labeled by Ellis are (a) awfulizing, (b) discomfort intolerance, (c) rigid, and (d) self- and other downing (Dryden, 2013).

In his book, *The Feeling Good Handbook*, David Burns (1999) identified 10 distorted thought patterns believed to be significant sources of psychological pain in people's lives: (a) all-or-nothing thinking, (b) overgeneralization, (c) mental filter, (d) discounting the positive, (e) jumping to conclusions, (f) magnification, (g) emotional reasoning, (h) "should statement," (i) labeling, and (j) personalization and blame (pp. 10-11). Grohol (2019) credited Burns with naming another distortion, "heaven's reward fallacy," a "false belief that a person's sacrifice and self-denial will eventually result in a heavenly reward" (para. 19). Suicidal ideation is believed to be a form of distorted thinking (Valach et al., 2016).

An example of a pastor's distorted/irrational belief statement is, "I need to be available 24/7" (Beals, 2016; Fee, 2018). This type of comment would fall under what Ellis classified as "musts, shoulds, have to's," and this type of thinking underlies "emotional disturbance[s]" (Joshi & Phadke, 2018, p. 5). Another statement, "I shouldn't take off during the week," is an example of a distorted

thought "should statement." An example of distorted jumping to conclusions is pastors being afraid "to let [their] parishioners know how they really feel" (Irvine, 2003, p. 10).

How a person thinks is central to internal and external functioning. Combining irrational beliefs and distorted thinking contributes to unhealthy emotions and behavior. Although gender as a factor in mental illness and help-seeking was not the focus of this study, in a research study of men with depression, a "negative state of mind" was found to be a source of emotional problems (Spillman, 2006, p. 10). Developing management, career skills, and overall behavior links to a person's cognitive processing (Duckworth & Yeager, 2015; Mennin et al., 2013).

Balkis and Duru (2019) used a sample of 440 college students to determine if the students' belief systems were a moderating factor for stress, depression, and anxiety. The Depression Anxiety Scale (DASS-42) was used to measure emotional state, and the General Attitude and Belief Scale (GAB-55) was used to identify irrational beliefs. Scores for emotional distress were predicted significantly by the irrational feelings of "need for achievement, approval, and comfort" (p. 102). A similar study by van Dijk et al. (2017) assessed 406 medical students, and the results of this research indicated that negative thinking might be a link to emotional stress. The irrational belief, self-downing, was positively associated with depressive and anxious feelings in Buschmann et al.'s (2018) sample of psychology students ($N = 542$).

Behavioral

Mental illness manifests behaviorally in different ways. According to Chiles et al. (2018), "suicidal behavior" is a "distinctive set of learned and reinforced responses to emotional distress" (p. 68). When a person decides suicide is an option, it is because of the failure to resolve and cope with the emotional and psychological stress (Chiles et al., 2018). There are several behaviors connected to mental problems. One action is the abuse of alcohol and other substances is a standard method people use to cope with life's stressors, and church leaders are not immune to engaging in this vice. The emotional and mental numbing effect of alcohol and drugs is a lure for their consumption to alleviate

depression, guilt, shame, and hopelessness. A few study results suggest that religious/spiritual beliefs prevent the development of a substance disorder (McClure & Wilkinson, 2020; Pointer, 2015; Unterrainer et al., 2014). Other research indicates a growing addiction among church ministers (BARNA, 2017; Craven, 2012). Another behavioral sign of psychiatric issues is that people tend to withdraw from family, friends, and social activities. Pastors typically spend ample time alone praying and communicating with God about their illnesses. Added pressure could lead to unhealthy isolation.

The Effects of Chronic Stress

When a person experiences a stressful event that surpasses the person's mental capabilities to cope, this can lead to physiological, psychological, and behavioral problems. Researcher Jean-Martin Charcot, in the 1800s, was one of the first to scientifically explore the concept of "hysteria," which in ancient times was seen as some "strange" psychological problem that only affected women who had experienced traumatic events (Herman, 1997, p. 10). Sigmund Freud and other researchers further defined psychological trauma as a process for dealing with the effects of wars.

The brain shuts down parts of itself related to emotion regulation and memory storage and recall to help people deal with helpless situations. The brain's protective response is how those with overwhelming stress can respond in a self-protecting manner. Maier and Seligman's (2016) study of animal reactions to traumatic actions concluded that not trying to escape painful attacks is a learned behavior. However, more recent research suggests that not trying to escape is not a learned behavior. When a person faces a life-threatening event, the brain's natural response is the "serotonergic activity of the dorsal raphe nucleus" (Maier & Seligman, 2016, p. 353). According to the National Institute of Mental Health (2019):

> Stress in various forms is an inevitable human experience that has positive and negative consequences if not dealt with promptly and healthily. Stress can be temporary or chronic, depending on the triggering event/s. The human body has a natural defense system activated by the brain to help a person survive real life-threatening ordeals or psychologically

> engineered fear responses. When a person loses the ability to manage life's challenges, this can devastate physical, mental, and emotional functioning. Many interventions include professional help for those struggling with uncontrolled anxiety and feeling overwhelmed. (pp. 1-2)

The level of support of friends and family and the quality of the victim's religious faith meditate stressful events that can happen to anyone at any time and the effects that potentially harmful acts can have on a person's mental and spiritual well-being (García et al., 2017). Experiencing repeated and differing forms of stress negatively impacts a person's psychological well-being (Simmons et al., 2015). Hendron et al. (2014) discovered the potential evidence of "secondary trauma" from working with distressed clients when they interviewed 16 ministers (p. 8).

Churches' View of Mental Illness

Fabrega (1991) reported on the involvement of the Christian church in theories and interventions on mental illness since its early development. Predominately, the 16th-century Catholic Church labeled anything related to psychiatric concerns as "sin, demonism, and madness" (Fabrega, 1991, p. 101). Lloyd and Panagopoulos (2022) employed a unique qualitative method, story completion, to reveal Christian beliefs about self-harm and mental illness. Lloyd and Panagopoulos (2022) had 101 participants from the U.K. who identified as Christian to use their imaginations to develop a short story from a preestablished sentence. The results of this study indicate that the participants viewed self-harm and mental illness as a form of demonic influence.

Christian churches remain divided on accepting the reality of mental illness, as described by secular theories—first, a look at the rejectors of secular views of mental illness. Stanford's (2007) online survey of 293 self-identified Christians intended to identify what church members thought about mental illness. Many of Stanford's samples of participants reported they felt unsupported by their church, with 21% believing psychiatric symptoms are demonic and 19% believing mental illness is because of a "lack of faith/personal sin" (Stanford, 2007, p. 448). Women were disbelieved more

than men for having a mental disorder. The results of Lloyd's (2023) qualitative review of 309 primarily female participants indicated an ongoing controversy within the church regarding the church's response to mental illness.

Churches Opposed to Secular Mental Health Theories/Treatment

Despite technological advances in how constant stress impacts the brain, several Christian churches still believe mental illness is a supernatural symptom of demonic possession or influence. However, there is growing public awareness of psychiatric disorders (Leavey, 2010; Lloyd & Panagopoulos, 2022; Sullivan et al., 2014). In Aramouny et al.'s (2020) sample of Catholic clerics, almost one-third believed psychiatric issues were from a mysterious cause. Frenk (2014) reviewed data from the National Congregation Study to identify whether churches provided mental health services (N = 1,506). This study found that only 8% of the clergy of this sample offered counseling services, but 92% did not have any mental health services.

Churches Open to Secular Theories/Treatment

There is a growing trend of increasing awareness and acceptance of psychiatric issues among Christian congregations. For instance, Wong et al. (2012) reported that about one-third of churches provide mental health counseling. The underlying cause for some churches transitioning from a purely supernatural view of psychological problems is identifying the younger generation and institutionally trained constituents (Aramouny et al., 2020; Kumi, 2016; Wong et al., 2012). The shift has led to more integration of spirituality with nonspiritual beliefs about mental illness (Aramouny et al., 2020; Kumi, 2016; Wong et al., 2012). Although a few Catholic clerics in Aramouny et al.'s (2020) study did not support secular theories, more than half believed mental problems were from psychosocial factors, including a traumatic past and the abuse of alcohol or illicit substances.

Paradoxically, in other cultures, the line between biblical and pagan beliefs about mental health is blurred. For example, Walther et al. (2015) completed a qualitative study that clarified the clergy's health concepts for UMC churches in Western Kenya. Walther et al. interviewed 49 clergy

members, and the results were fascinating. According to Walther et al. (2015), "The clergy commented that although Jesus saves them, they are still Luo (belief and use of witches and magic), and their culture cannot be taken out of them" (p. 11). Walther et al. (2015) pointed out that lacking social support may link to clergy members' emotional issues.

Suppose a person uses a search engine such as Google for "what are churches doing for mental health." The first results show a few church websites that offer mental health services, such as Saddleback Protestant church, Christ Episcopal Church, the UMC, Prestonwood Baptist Church, and Fellowship Church. In that case, most search result links are "about" various stories or guidelines for churches and mental illness. As mentioned earlier, only a small percentage of churches appear to offer mental health support. The type of services provided are typically "pastoral [and] lay counseling, church support groups, and spiritual care" focused on external clients, not specific to the minister's mental health (Bornsheuer et al., 2012, p. 201).

When it comes to the church's care for its pastors, information is lacking. Nieuwhof (n.d.) stated that the "pastoral care model of church leadership" does not support what these leaders need. Scott and Lovell (2015) sought to address the lack of pastoral services by providing an 18-month program specific to clergy, the Rural Pastors Initiative. Of the 54 participants, 34 completed the study, which included a standard survey of participants every 6 months for the experiment's duration. This study reported that the Rural Pastors Initiative did help improve some mental and spiritual functioning but not self-care. Scott and Lovell (2015) advised that programs must strengthen pastors' judgment about self-care because they believe it is selfish to take time for self-recovery. In another study, two pastors in Bledsoe and Setterlund's (2015) qualitative survey of 16 pastors from various denominations found therapy to help learn and improve personal mental functioning.

Gill et al. (2019) reported that many churches "provide annual spiritual retreats" for their pastors (p. 3). Stetzer (2018) provided a list of retreats for pastors throughout the United States; however, some of the sites' links were no longer active, and some of the retreats required a fee.

Several more websites maintain pastor retreat resources with the same issues; defunct links or retreats have a cost, while some are free, but their availability varies. Cafferata (2020) noted that financial difficulties are a significant part of pastor stress. A few participants in their study reported they could not afford to go on a retreat and did not feel they had the time to go somewhere for rest.

Summary

The literature review shows that the topic of help-seeking for mental health problems is a complicated endeavor. The researcher predicated the validity and reliability of this study on a sound, research-established theoretical foundation. Heidegger's interpretative phenomenological philosophy theory is a thoroughly studied and often-employed philosophy for qualitative research. The other philosophies guiding this study were the TPB and CDHS. Mental diseases affect millions of people worldwide, and help is available through various therapeutic interventions. Statistically, these services have yet to be accessed by those who need them. Church leaders deal with multiple problems that contribute to developing mental issues. Preventive actions are there for pastors to learn and practice to ward off becoming overwhelmed in their roles. Maintaining proper boundaries is one of the essential prevention skills the clergy needs. Addressing distorted and irrational beliefs is vital in healing and preventing severe psychiatric problems. Although researchers had labeled speculation in heavenly rewards for earthly suffering as distorted, the Bible talks extensively about the "great rewards" awaiting those who have suffered for Christ and endured various trials. Also, a researcher concluded that belief and following biblical principles are reinforcements against psychological distress. Bible truths are a source of hope for many clergy members. Mental disorders are an extensively studied topic that carries over into other fields. The Christian church has continued to play a role in the psychiatric realm, although there is still a split between churches that believe mental issues are other-worldly versus those that support human-conceived theories.

CHAPTER THREE: METHODS

Overview

This phenomenological study explored the experience of church leaders with mental health problems. This chapter discusses the design plan of an interpretative phenomenological study: the researcher's semi-structured interviews, a restatement of the leading research questions, the research setting, a description of participants, procedures, the role of the researcher in data collection and analysis, and ethical considerations.

The researcher chose an IPA methodology. The researcher obtained the "individual perspectives in context" of the mental challenges of being a leader in the Church (Heppner et al., 2015, p. 357). IPA's foundation comprises theoretical ideas from phenomenology, hermeneutics, and idiography (Smith & Nizza, 2022). According to Court (2018), qualitative research explores humans' unique and complicated lives without preconceived hypotheses. One goal of the phenomenological study is to explore the "what-of" of human experiences and not the "why" (Van Manen, 1990, p. 9). Here is a brief review of the theory.

Interpretative Phenomenological Analysis

IPA was initially developed by Johnathan Smith in 1996 (Smith et al., 2009). Smith wanted to "stake a claim for a qualitative approach centered in psychology" that centered on the experiential (Smith et al., 2009, p. 10). An IPA researcher seeks to uncover information about a person who has experienced or is experiencing a life-impacting event (Smith et al., 2009). According to Smith et al. (2009), "IPA recognizes that access to experience is always dependent on what participants tell us about that experience and that the research then needs to interpret that account from the participant to understand their experience" (p. 9). Hans-George Gadamer is the man cited for expanding this form of phenomenological theory into more practical usability (Malpas & Zabala, 2010, p. xi). IPA is "informed by hermeneutics" stated Smith et al. (2009, p. 9) by taking the concept of "thrown into," the idea that human beings, at no fault of their own, are a part of "a world of objects, relationships,

and language. Secondly, our being in the world is always perspectival, always temporal, and always 'in relation to' something" (Smith et al., 2009, p. 34). IPA also uses the hermeneutic circle and reflective process in reviewing data that require "a cyclical approach to bracketing" (Smith et al., 2009, p. 40). The goal of IPA is to interpret the details of an individual's meaning-making experience and an individual's thoughts and beliefs about the event (Smith et al., 2009). According to IPA principles, the researcher has a "dual role," using the participants' communication and mentalization skills to help them understand their experiences (Smith et al., 2009).

Design

This study purposively recruited 15 church leaders from Dallas, Texas, with a history of mental health problems during their time as church leaders. The IPA methodology was the philosophical basis for this study of church leaders' help-seeking behavior. Moustakas (1994) stated that the essence of phenomenological research is to reject the manipulative experimental design; instead, the researcher is to "return to [personal] experience to obtain comprehensive descriptions . . . for a reflective structural analysis that portrays the essences of the experience" (p. 10). Moreover, Smith and Osborn (2008) stated, "IPA is a suitable approach when one is trying to find out how individuals perceive the particular situations they are facing, how they are making sense of their personal and social world" (p. 53). Alase (2017) stated that IPA allows participants to be researched in a non-prosecuting manner, which is essential given the stigmatizing and sensitive mental illness topic. The researcher chose purposive sampling to focus on a specific target population. Purposive sampling findings can be more generalizable (Conner et al., 2009; Daniel, 2012). A semi-structured interview was the qualitative method to understand better the intentions, beliefs, and behaviors involved in church leaders' help-seeking realm. Although this topic is personal and sensitive, this research interviewer has experience working with severely mentally ill adult clients in hospital and outpatient settings.

Research Questions

RQ1: What are the lived experiences of church leaders with mental illness?

RQ2: What were church leaders' experiences with help-seeking during their mental health episodes?

RQ3: How were church leaders' relationships during the mental health episode?

Setting

The researcher recruited participants via Facebook.com. Also, this researcher purchased a list of church leaders from a data collection company. The researcher also recruited via email addresses obtained directly from church websites. The researcher used the same flyer/recruitment letter for all participant solicitation methods. The interviews took place based on the agreed-upon date, time, location, or online platform between the participant and researcher. The inclusion criteria were church leaders who had been professionally diagnosed or self-diagnosed to have a mental illness problem when they were in a leadership position in a Christian church. Fifteen participants scored above 25 on the Mental Health Inventory-5 (MHI-5), met the criteria for the sample frame, and agreed to be involved in the study. After the interviews and discussion with the IPA coach, the researcher excluded four participants who completed the interview. This researcher established rapport by starting each interview with general topics before addressing the sensitive issue of mental illness, as qualitative researchers Namageyo-Funa et al. (2014) recommended. Participants were followed up by email.

Participants

The researcher collected a purposeful sample of 15 Christian church leaders aged 20 years or older between April 2021 and July 2021. Although there was no standard age requirement to become a pastor, the researcher determined the starting age range of 20 years old because of the data reported by Earls (2017) and Boyd (2018) that some leaders start Christian ministry in their 20s. According to Smith and Shinebourne (2012), "IPA utilizes small, purposively selected and carefully situated samples" (p. 55). This researcher stopped recruiting at 15 because the saturation of the collected data

had been met (Saunders et al., 2018). After reviewing interview transcripts, the researcher excluded 4 of the 15 in the analysis for different reasons. The participants had to have had an emotional/mental illness experience that lasted more than two weeks as a minister. All participants were fluent in English, but it did not need to be their native language. The participants were currently employed in their leadership position. Although the study was open to church leadership titles of pastor, reverend, bishop, minister, priest, clergy, or pastoral counselor, the only titles represented in this study were pastor, reverend, and minister. The primary religious affiliations were pastor $N = 6$, minister $N = 5$, and reverend $N = 1$.

The researcher chose to use biblical names as pseudonyms based on gender per Liberty University's EDCO 2022-2023 dissertation handbook (n.d.). Using pseudonyms was to protect the participants' confidentiality. Biblical names were randomly picked with no relation to the biblical person's life as presented in the Bible. The use of Bible names versus other names is based on the fact that the subjects of this study were Christian leaders. Milacci (n.d.) discussed the ethical concerns in not using pseudonyms in qualitative research, "We need to get the protection of the participant's identity, we do that by using pseudonym, and this is something I'm a stickler about, we don't call our participants, participant one, participant two, they are people" (05:40).

Table 1

Participant Demographics

Participant No.	Age Range	Marital Status	Ethnicity	Religious Affiliation	Leadership Title	Years in service	Degree Level	Salary Range	Gender	MHI-5 score	Support	Training
P1	35-44	D	A	COC	Minister	19+	M	$77+	M	36	Oth F, F, C, Oth P/CL, T	College
P2	35-44	M	W	Non-Den	Minister	10+	M	$47+	F	64	Sp, Oth, F, Oth P, T	Seminary
P3	45-54	M	W	Baptist	Pastor	19+	M	$77+	M	52	Sp, Oth P, T	Seminary

P4	55-64	M	W	Methodist	Pastor	41+	Doc	$77+	M	76	Spouse	Seminary
P5	55-64	M	A	Methodist	Pastor	40+	Doc	$26+	M	64	Church	Theology
P6	55-65	M	W	Other	Minister	25+	Doc/PD	$47	F	69	Sp, Oth, F, Oth P, T	Formal
P7	35-44	M	W	Baptist	Pastor/PC	20+	M	$77+	M	52	S, O, F, C, Oth P, T, Oth	Theology
P8	45-54	M	W	Baptist	Pastor	20+	A, PD, V	$77+	M	72	S, O, F, C, Th	Seminary
P9	25-35	M	W	COC	Minister	6+	M	$57+	M	72	S, O, F, Oth P	University
P10	25-35	M	W	Baptist	Minister	13	M	$77+	M	52	S, F, C, Oth P, Therapist	University
P11	35-44	M	W	Non-Den	Pastor	13	M	$67+	M	60	S, F, Oth P, Therapist	Seminary

Note 1. Marital status D = Divorced, M = Married; Ethnicity A = African American, W = White; Religious Affiliation COC=Church of Christ, Non-Den=Non-denominational; Leadership PC = Pastoral Counselor; Degree Level M = Master's, Doc = Doctorate, PD = Professional, A = Associates, V = Vocational; Gender M = Male, Female = F; Support Oth F = Other family members, F = Friends, C = Church, Oth P/CL = Other pastors/church leaders, T = Therapist; Salary Range 26+ = $26,000 to $37,000 47+ = $47, 001 to $57,000 57+ = $57, 001 to $67,000 67+ = $67, 001 to $77,000 77+ = Above 77,000. *Pseudonyms are used for each participant to protect their identity*

Participant Exclusions

The criteria to exclude study participation: (a) religious leaders from other faiths, (b) participants with different positions in the church such as deacon, choir/music director, supervisor, or elder (unless the pastor is holding more than one job), (c) Christians not in one of the identified leadership positions, (d) participants who were actively suicidal, (e) participants who do not meet the sample frame criteria, (f) participants who scored lower than 25 on MHI-5. The researcher excluded two potential participants who completed the initial screening questionnaire. The researcher excluded one because they did not have a history of mental illness. The researcher excluded the other after the researcher sent several emails over several weeks about scheduling the interview and never received a

return message. After the researcher analyzed each transcript, the researcher excluded four of the participants. The excluded participants were Moses because he was the pilot interviewee, Sarah, whose mental health issues were before becoming a pastor, and Elijah and Naomi because their issue was primarily related to unresolved grief.

Procedures

The Researcher's Role

This researcher was the primary instrument and the objective interpreter of the participant's responses to the survey. This researcher did not have any personal connections with any of the participants. Nor was the researcher a member of any organized church, so there were no conflicts of interest. According to Sutton and Austin (2015), "the role of qualitative research is to attempt to access the thoughts and feelings of study participants" (p. 226). The authors explained what this study strove to do, revealing all the elements, such as mental health and help-seeking, or helping to avoid today's behavior. The researcher did not have educational or professional authority over the participants.

Data Collection

Smith and Osborn (2022) stated that semi-structured interviews are the pinnacle for IPA research (p. 19). This researcher used open-ended questions to gather participants' thoughts and perspectives with "as little prompting from the interviewer," which was the primary point of IPA research (Smith & Osborn, 2008, p. 61). According to Miles et al. (2014), structured analysis is more appropriate for novice researchers who usually do not have the time or experience to explore "complex social phenomena" (p. 36). Bevan (2014) explained that phenomenological interviewing is one of the best qualitative methods for analyzing the inner experiences of participants, and this is why this researcher chose interviewing as the method for data collection.

The process for collecting the data was as follows. The screening form to determine eligibility was online through a secure website. In accordance with human research studies, this researcher

created an informed consent form detailing the study's purpose, benefits, risks, and participation expectations. This researcher obtained informed consent from eligible participants via DocuSign, a secure online electronic signature program. The researcher scheduled the interviews. Only one interview was in-person, and the researcher conducted the remaining 14 via Zoom—the researcher communicated with participants via email to obtain an agreed-upon date and time for the interview. The researcher sent a Zoom invitation with a secure link for the agreed-upon day and time. The researcher followed an interview. Aside from the open-ended prepared interview questions, during the interview, other clarifying questions were asked based on statements made by participants who were in line with the IPA expectation of "going deeper" to obtain more quality details (Smith et al., 2009, p. 68). The interviews lasted 46 to 70 minutes, and the researcher recorded the interviews using the Zoom application. The researcher assigned each participant a biblical name based on gender to protect the participant's identity. The researcher stored the recordings in a password-protected folder on a universal serial bus drive. This researcher collected all research data.

Seven recorded interviews were transcribed verbatim by staff from GoTranscript.com (n.d.), an online HIPAA-compliant company providing transcription services since 2005. GoTranscript (n.d.) guarantee their services are secure in the protection of the confidentiality of data by maintaining files on their "own servers so they cannot be assessed by outsiders, the transcriptionists are always monitored, and after the transcription is complete, we delete the file from our system" (para. 5). GoTranscipt.com (n.d.) also received the "HIPAA seal of compliance," validating their commitment and effectiveness in securing client data. Due to financial barriers, this researcher transcribed the remaining eight interviews. The researcher stored the transcripts in the same drive as the recordings. None of the participants needed any local or national resources.

Interview

Demographic information included age, marital status, support system, ethnicity, denomination, leadership title, years in service, education, gender, location, ministry training, and salary. The standardized open-ended semi-structured survey questions were:

1. What does the term *mental illness* mean to you? How do you define it?
2. Experts report that church leaders are stressed, and many have emotional problems such as depression and anxiety. What do you think about this?
3. There are news reports worldwide of pastor suicides. What do you think about this?
4. Could you describe your thoughts and emotions during the time of the mental health episode?
5. Could you describe what you thought to do about your mental symptoms?
6. What do you think contributed to your mental health symptoms?
7. What did you think about yourself when you had mental health issues?
8. Daily basis, how do you deal with depression or other mental symptoms? Prompt: Do you have strategies for helping yourself or ways of coping, practical or mental?
9. What do you think about your future?
10. What do you think pastors who are depressed or suicidal should do about it?
11. Could you describe how your current church helps you?
12. Could you describe the quality of your relationships?

Questions one through five were designed to understand the church leaders' experience from their perspectives related to mental health and illness (Court, 2018). Question six relates to Roepke and Seligman (2015). They posited that identifying future orientation is linked to depression in that a person with sad thoughts about their future is more likely to suffer from mental distress. Moreover, Ajzen (2005) stated that future orientation depends on what a person did in the past. Questions six through eight were designed to obtain the personal meanings of the sufferers of mental illness experience, the core purpose of IPA research (Smith & Osborn, 2008). Sasso (2012) indicated that the extraversion personality trait contributes to the seeking and effectiveness of therapy.

In contrast, avoidant characteristics are linked to the impediment to forming the critical therapeutic alliance leading to ineffective treatment. It could be argued that church leaders with more extroverted personalities may seek help more than those with introverted or avoidant personalities.

Still, this hypothesis would require another research study with church leaders who are struggling mentally. Question nine obtained the pastor's thoughts and attitudes toward TPB theory's [help-seeking] behavior aspect. The client's characteristics partially determine the therapeutic interventions' effectiveness, so question nine was designed to identify helpful or unhelpful factors for those who sought mental distress (Sasso, 2012). Questions 10, 11, and 12 were linked to help-seeking being intertwined with support from others, and how supported pastors felt from their congregation was identified as a motivating factor (Arnault, 2009). This research acknowledged the negative side of using structured questions, which could cause the researcher not to have access to other information that could be important for the study (Smith & Osborn, 2008). The research questions for the semi-structured interview were developed based on the guidelines from IPA and qualitative studies (Alase, 2017; Brocki & Wearden, 2006; Smith & Osborn, 2008).

Textual data were obtained from recorded and transcribed interviews and interpreted using concepts from IPA, TPB, and CDHS. The completed transcripts were forwarded to participants to review and make any adjustments or additions before starting the analysis. One participant, Amos, corrected the spelling of a French word; another, Elizabeth, provided corrections related to parts of her story. The remaining participants agreed on the transcripts without any adjustments. The researcher recorded the data, transcribed the interviews, and confirmed the accuracy of the transcripts by the 11 participants. This researcher printed out the transcripts and followed the IPA method for analyzing each case.

Pilot Testing

Pilot testing is a standard procedure for ensuring qualitative study results are valid and reliable (Gani et al., 2020; Van Wijk & Harrison, 2013). This researcher conducted a pilot interview with the first participant, Moses, to ensure the questions were appropriate. This researcher learned the actions for a successful interview (Majid et al., 2017). Having others experience the questions helped identify whether the wording did not convey or elicit the researcher's desired interviewee responses (Makin, 2005). This researcher also obtained a coach who was an expert in IPA analysis to help guide the

process.

Data Analysis

This researcher used two methods to code and analyze the data. The first method was IPA's "bottom-up" process comprised of intricate focus, reading, and documenting on single cases to the building of "clusters of raw material" to identify "emerging patterns" to develop themes among all cases (Larkin, 2020). For documenting initial notes, this researcher needed to maintain a "phenomenological" mindset and classify notes as descriptive, linguistic, or conceptual (Larkin, 2020; Smith et al., 2009). The goal in the process of reading, documenting, and phenomenological reasoning of the data was to identify "objects of experiential interest" (Larkin, 2020). The reporting was built upon each review of single cases, linking the identified personal meanings across cases to develop a more interpretative, analytical, and elaboration narrative dialog (Larkin, 2020; Smith et al., 2009). This researcher kept a reflective journal throughout the process; another expectation for this type of coding was to ensure transparency (Vicary et al., 2017).

The researcher printed each transcript and followed the IPA analytic process per Smith (2020). After reading the transcript, the researcher completed initial exploratory notes by examining transcripts line by line. Next, the researcher interpreted initial notes to develop "experiential statements." The researcher reviewed the experiential statements to classify similar ideas to create "clusters." The researcher developed a themes table using Excel to cluster the experiential statements.

In the initial analysis process for the first transcript, Abraham identified three superordinate themes. The researcher re-reviewed to detect words that could be eliminated, combined, or regrouped into sub-clusters because each cluster had many experiential statements (Smith, 2020, p. 47). The research used the same process for the remaining 10 transcripts. A cross-case analysis was the final stage to clarify how the 11 participants' experiences compared to each other and the differences and to develop the group experiential main and subthemes. After the manual IPA analysis method, this researcher used the MAXQDA online program to reanalyze the data to ensure validity and credibility (Gassin, 2020; VERBI Software, 2022).

The second method was applying the IPA technique through the MAXQDA software program. Using MAXQDA, the analytical process involved uploading the transcripts, focusing on one case at a time, completing a line-by-line review, and making initial exploratory notes using the "memo" function. The memos were color-coded to label the memo as descriptive, linguistic, or conceptual per the IPA method. The researcher completed all the memos for one case, created an "all memos report," and then uploaded the report to cluster the initial statements and code them as experiential statements. The researcher clustered the experiential statements to create the superordinate and subthemes for each case. Each participant had a final memo that listed the superordinate themes for that document set. The researcher grouped and coded clustered experiential statements once each transcript underwent the memoing process. The researcher created all the superordinate and subthemes from the clustered and coded groups. Then a report of the superordinate themes was generated. The researcher completed the cross-case analysis using the report of the superordinate themes to develop the superordinate and subthemes.

Trustworthiness

Trustworthiness involves all the factors contributing to the belief in a study's reliability and validity and that the results are well-supported with clear and precise data (Robson, 2011). Lincoln and Guba (1985) established four criteria an investigation must employ to bolster the "rigor" of a study's process and findings: credibility, dependability, confirmability, and transferability.

Credibility

This researcher correctly identified and described the participants to ensure credibility (Elo et al., 2014, p. 2). During each interview, the researcher stated each participant's number and their corresponding pseudonym. This research provided the credibility of this study by sending the completed transcripts to the participants before the analysis process to confirm that the transcription of their stories was correct (Birt et al., 2016). The researcher marked each transcript with the pseudonym of each participant. The analysis process included writing exploratory and interpretive notes directly on the transcripts for each participant. The researcher followed the IPA analytical

guidelines by reading the transcripts repeatedly, writing notes, and highlighting thought-provoking words and sentences, identifying the data that best illuminated the participant's experience. This process for each transcript led to the creation of hundreds of notes and hundreds of experiential statements; after clustering and paring down the experiential statements, the researcher established the central and subthemes. Quotes from each participant supported the findings. Another action to improve this study's credibility was using member checking by sharing the results with participants to validate the conclusions (Petty et al., 2012).

This researcher previously collected the participants' email addresses and reached out to each participant to confirm their preference for receiving a copy of Chapter Four results for their review. Asking for their preference before sending the draft helped to empower their decision to participate in the member-checking process (Birt et al., 2016). The researcher asked the participants to review the preliminary results section to confirm that the researcher had correctly displayed their experience in the analysis. The researcher asked the participants to review the document and make any comments, corrections, or adjustments. The 11 participants emailed that they had reviewed the results, and none had any corrective or disagreeing comments.

This researcher had their chair and an external auditor review the data with the researcher to "increase comprehensively and sound interpretation of the data" (Elo et al., 2014, p. 5). This researcher accepted the challenge of producing reliable interpretations. The best practice is to have other investigators "familiar with the research topic . . . evaluate whether the results match reality" (Elo et al., 2014, p. 6), for which this researcher hired an IPA expert for coaching through the analysis process.

Dependability and Confirmability

Whether the interview data were "stable over time and under different conditions" was better assessed once the data were analyzed (Elo et al., 2014, p. 4). This researcher enhanced reliability by adhering to a pre-prepared interview schedule as closely as possible for each interview (Smith & Osborn, 2008). This researcher detailed the principles and criteria the researcher used to include

participants in the study (Elo et al., 2014). Another aspect contributing to this area was that the participants were the best to talk about this experience because of their years in church leadership (Morse et al., 2002).

Data Collection Method

Semi-structured interviews were the appropriate data collection method per the IPA method (Smith & Osborn, 2008). This researcher acknowledged being a novice researcher but an experienced interviewer from providing over 20 years of mental health counseling services. This researcher had the help of graduate-level mentors. The interview questions were pretested by interviewing a prestudy participant.

Sampling Strategy

Purposive sampling was the overarching framework, and this researcher used a homogenous and intensity sampling method. Purposive homogenous sampling was the best method for IPA research (Smith & Osborn, 2008). According to Brocki and Wearden (2006), IPA is unlike other philosophical theories, such as the grounded theory that uses theoretical sampling. Instead, IPA uses purposive sampling "to select participants to illuminate a particular research question and to develop a full and interesting interpretation of the data" (Brocki & Wearden, 2006, p. 95). The plan to use a small sample of participants aligned with typical IPA studies for the small sample allowed for a "detailed interpretative account," which is confusing, more time-consuming, and costly to do on larger sample sizes (Smith & Osborn, 2008, p. 56). Purposive sampling was appropriate because this researcher intended to interview pastors with experience with mental illness during their time in church leadership. The pastors knew their experiences; they were not second-hand unknowable subjects (Elo et al., 2014).

To establish initial eligibility, participants had to fit within the sample frame, and interested participants were prescreened using the mental health assessment, the Mental Health Inventory-5 (MHI-5). After the researcher completed the interviews, 4 of the 15 participants were excluded based on not fitting the criteria as their mental health episodes were outside the frame of occurring within

the aspect of being a church leader.

The Mental Health Inventory-5

The MHI-5 is the short form (five items) of the original Mental Health Inventory created by Veil and Ware in 1983. The MHI-5 is an instrument to access the mental functioning of patients along with the impact of "health care financing arrangements on demand for services" (Coombs, 2005, pp. 6-7) as part of the "RAND Corporation's Health Insurance study" (Santos & Novo, 2020, p. 1454). This inventory was open to the public to use without permission (RAND Corporation, n.d.). The established cutoff point was between 52 to 68; scores ranged from 0 (severe mental issues) to 100 (Houghton et al., 2010; Thorsen et al., 2013). The cutoff point established by Kelly et al. (2008) was 76. The MHI-5 has been tested and validated for the benefit of using this scale since its creation. Berwick et al. (1991) confirmed this scale's accuracy compared to other longer psychological tests to detect mental health disorders reporting curve scores under .739+ for anxiety disorders and .892 for significant depression (p. 169). Yamazaki et al. (2005) reported similar results when they tested the MHI-5 on general Japanese citizens, $N = 4500$. Yamazaki et al. published under curved scores of .942 for depression (p. 1). Santos and Novo (2020) tested the MHI-5 on small comparison samples, adults with ($n = 33$) and without clinical complaints ($n = 31$). The 5 MHI items are:

- Have you been a very nervous person?
- Have you felt so down in the dumps that nothing could cheer you up?
- Have you felt calm and peaceful?
- Have you felt downhearted and low?
- Have you been a happy person? (Yamazaki et al., 2005, p. 2)

Sampling Unit and Frame

The sampling unit was a church leader. The sampling frame consisted of the following:

- licensed or ordained Christian church leader (i.e., minister, clergy, reverend, priest, or pastoral counselor),

- adult age 20 or older,
- currently employed full or part-time in a church,
- current or past mental health episodes during their time as a church leader,
- a positive score on Mental Health Inventory-5, and
- live within 50 miles of Dallas, Texas,
- the participant's unique identifiers will be pseudonyms names.

Selecting The Unit of Analysis

The analysis unit transcribed words spoken by the participants and recorded and interpreted by the researcher. This researcher followed the IPA analytical process by reading the transcripts repeatedly and noting "interesting or significant" words and statements (Smith & Osborn, 2008, p. 67). This first step was repeated in all the interviews, and during this process, this researcher looked for "emerging theme titles" (Smith & Osborn, 2008, p. 68). As noted by Smith and Osborn (2008), "The initial notes are transformed into concise phrases which aim to capture the essential quality of what was found in the text" (p. 68). The next step was "clustering the themes," which "involves a more analytic or theoretical ordering, as the research tries to make sense of the connections between [emerging] themes" (Smith & Osborn, 2008, p. 68). Smith and Osborn stated that researchers could use the initial transcript analysis themes as a template for the other transcripts. The researcher paid attention to possible new themes in the other interview. The last stage of the analysis involved the narrative write-up of results, where the researcher extensively broke down the themes (Smith & Osborn, 2008, p. 76). Smith and Osborn recommended two ways to present the data; the one this researcher used was to show the results detailing "the emergent thematic analysis" and write up the discussion as a separate chapter, "[linking the] analysis to the extant literature" (Smith & Osborn, 2008, p. 76).

Transferability

Transferability is the ability to apply the results of this study to other situations or participants. This researcher detailed the participants' primary characteristics without disclosing specific identification to ensure transferability (Moretti et al., 2011). The researcher provided "thick descriptions" of the "setting, context, people, actions, and events" (Petty et al., 2012, p. 382). The researcher engaged in "purposive sampling" and kept a "reflexive research journal," which are activities to help confirm transferability (Petty et al., 2012, p. 382).

Ethical Considerations

The study commenced after receiving approval from Liberty University IRB (#FY20-21-68). The researcher provided participants with written and verbal information about the study, including the purpose and procedures, voluntary participation, and the opportunity to withdraw at any time. Potential participants were informed about the gift card for participation on the flyer/invitation letter and reminded at the interview. Accepted participants were guaranteed confidentiality within the limits of the interview procedures and were required to sign an informed consent form. This researcher used no deceptive or misleading practices, followed ethical interview practices, and explained the researcher's role.

Risks to Participants

Participation in this research had the potential to cause psychological harm in the form of "undesired changes in thought processes and emotions (e.g., episodes of depression, confusion . . . feelings of stress, guilt, and loss of self-esteem); and these changes may be transitory, recurrent or permanent" (University of California, n.d., p. 2). Although the risk of psychological harm was "minimal or transitory," this research took the necessary protection precautions (Mirick & Williams, n.d., para. 6). According to the National Research Council (2014):

> Minimal risk means that the probability and magnitude of harm or discomfort anticipated in the research are not higher in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests. (p. 6)

Another risk was the potential for "identification of the participant by self or others" (Richards & Schwartz, 2002, p. 137). The risk of identification was because the personal information gathered about health care could give "clues" to a participant's identity, which, if revealed, could cause "prejudice and reprisal" in a participant's social network (Richards & Schwartz, 2002, p. 137).

Although there were minimal risks in any research project, qualitative studies have been shown to be safe and effective when researchers follow proper ethical protocols (Hadjistavropoulos & Smythe, 2001; Jagosh et al., 2012; Morse et al., 2008; Walker, 2007).

Plans to Minimize Risk

The researcher obtained informed consent to ensure that participants clearly understood the purpose and method of the research. The consent form was available to view on the online questionnaire. The consent form informed the participants that this study involved audio and videotaping the interview. The informed consent form was reviewed and signed by the participants via the secure DocuSign (n.d.) portal. DocuSign (n.d.) is certified to employ stringent security protocols for the protection of private data.

None of their personally identifiable information was associated with the recordings. The document provided information about tape transcription, the production of presentations or written products, the anonymity of the data, and how the researcher coded, stored, and disposed of the data at the end of the study. The meeting location was secured to ensure complete privacy from the public and protect the confidentiality of the researcher and participant. The meeting location was mutually agreed upon to address any accommodations for health-related issues. There was only one in-person interview; the remaining were via secure video individual Zoom conferences. Using online resources in research is a growing trend (Archibald et al., 2019; Hanna, 2012; Hesse-Biber & Griffin, 2012).

Archibald et al. (2019) evaluated Zoom to interview 16 nurses. Archibald et al. (2019) reported that the process had some technical issues, but overall, it was a successful endeavor. During some Zoom interviews, there were technical difficulties with the interruption of video recording, but the discussions continued. This researcher is experienced in using videoconferencing and the Zoom internet application as a source for counseling. Zoom maintains security by allowing hosts to log in with a password known only to the host and the person the host invites to the video meeting. In addition, chat information is encrypted. Participants in Zoom conferences can choose whether to show themselves on video. One participant decided to leave their video off during the Zoom session. The researcher coded the interview information to remove any direct identifier to participants.

Participant Compensation

Participants who completed the interview were each compensated with a $50 Visa gift card. To receive the gift card, participants had to have completed the interview. Participants understood they could withdraw anytime, but they would be disqualified from the reward if they withdrew early. According to the Office of Human Research Protections (2018), “Paying research subjects in exchange for their participation is a common and, in general, acceptable practice” (supra note 43). The reward amount was congruent with standard research expectations for paying participants to participate in studies. The payment was not too high or too low. The reward was not expected to cause undue influence or coercion, as participants could decide to drop out at any time. The researcher did not expect participants to benefit directly from the research, and this investigation was not experimental (Largent & Lynch, 2017). This researcher included a monetary reimbursement because they recognized that time commitment could be challenging for busy pastors (Largent & Lynch, 2017, p. 8). Also, as Largent and Lynch (2017) stated, this researcher wanted to show appreciation for participants’ willingness to open up about their personal and delicate stories (p. 8).

Furthermore, the participants this research sought to interview were not a part of a marginalized population, as pastors were expected to be employed. The money received for

participating in this study was not to supplement their income (Davidson & Page, 2012). Two of the 15 participants declined to receive the virtual gift card, citing that they were happy to contribute to the study and did not want any compensation. Participants were sent an email link from the company that provided the gift card. None of the participants had an issue receiving or using the virtual gift card.

Interviewer Bias

Although interviewing is a common and effective qualitative research method, the research needed to address bias since the researcher was the key "instrument" to gathering the data. Krishna et al. (2010) defined research bias as unintentional and intentional actions that can influence and alter study outcomes (p. 2320). Interviewer bias is "a systematic difference between how information is solicited, recorded, or interpreted" (Pannucci & Wilkins, 2010, p. 621). Most research can have random and systematic biases (Krishna et al., 2010). Given that this was a qualitative study, random bias was not a concern (Krishna et al., 2010). This researcher recognized their religious beliefs in the authenticity of the Bible and God. The confidence in the effectiveness of therapeutic interventions and the importance of stable pastors could have played a part in the interpretation of the transcripts; however, this researcher was not concerned that personal beliefs would overshadow the objective goals of this research.

One form of systematic bias this study could have had was a recall or memory bias. Salazar (1990) stated that the interviewer could include discrimination in the content and presentation of questions. None of the participants appeared to have difficulty recalling their stories.

Recall or Memory Bias

The researcher asked participants about past experiences, and according to Krishna et al. (2010), people talk more about "positive events than negative ones," increasing the chance that this researcher could question participants differently (p. 2322). This researcher used semi-structured

questions and asked clarifying questions to reduce the possibility of recall/memory bias, and the researcher recorded the interviews.

Interpretation Bias

This research used the IPA method, requiring this study's interpretive aspect. Still, the risk of interpretive bias was inherent in the process because "interpretation is never completely independence of [researcher's] beliefs, preconceptions, or theoretical commitments" (Kaptchuk, 2003, p. 1455). This researcher addressed this bias by having the transcripts evaluated by another reviewer to compare and confirm the data's correct interpretations.

Sampling Bias

Although this study was at risk for nonresponse sampling bias, given the combination of the sensitive topic of mental disorders and the pastor's inclination to hide their problem, this researcher did not have any problems recruiting participants. This researcher's plan to lessen sampling bias was developing and following the sample frame. According to Glen (n.d.), other ways to limit nonresponse that this researcher employed were "sending reminders to respond, offering incentives to respond, [using a short survey], and reiterating to participants of the protection and confidentiality of their personal information" (para. 9).

Summary

IPA was the chosen method for performing semi-structured interviews of church leaders. IPA was the option over other philosophical theories. IPA was identified as one of the best methods to elicit the rich personal perspective of research participants and allow this researcher to examine and interpret the lived experiences of research participants. The target population was Christian church leaders titled pastor, minister, clergy, reverend, priest, or pastoral counselor, regardless of denomination or non-denomination. The researcher recruited participants using purposive sampling from advertising on social media, email, and church websites. This researcher compensated

participants with a $50 Visa gift card for completing the interview through an online gift card company.

All studies come with some form of risk to participants, and this research had the minimal potential for psychological and participant identity revelation consequences. This researcher minimized the risks with no prior knowledge or relationship with the participants; the researcher coded participants' identities to prevent external ID; interviews were as confidential as possible. The questions developed for the discussions aligned with the IPA style's expectations, as they were not closed-ended; instead, the open-ended questions were participant-oriented. The questions were also framed broadly without any preconception. The interview occurred at the agreed time and place, face-to-face or via the Zoom online internet application; the Zoom platform's audiotape recorder recorded the discussions. GoTranscript.com and this researcher transcribed the interviews. This researcher followed the guidelines for analyzing the transcribed text manually and by MAXQDA to identify "themes and connections within the text" unconnected to preexisting theoretical philosophies. The researcher followed all ethical standards.

CHAPTER FOUR: FINDINGS

This study sheds light on the experience of church leaders who have experienced a mental health episode during their leadership in the church: first, a brief discussion of the participants' demographics, next, a non-identifying description of each participant using their pseudonyms. The following results section reviews the primary and subthemes identified from the IPA analysis of the pastors' interviews and research question responses. A chapter summary is the final section.

Through semi-structured interviews, participants shared their experiences with mental illness. There were common aspects that all participants had, but each had a few unique qualities and consequences during their mental health episodes. Each pastor showed how experiencing a significant mental illness had negatively impacted nearly all areas of their lives.

Demographic Data

Eleven participants provided insight into their experience with mental issues by participating in one semi-structured interview. This small sample size was predominantly male (99% male, $N = 9$; 22% female, $N = 2$) and White (99% White, 22% Black). All the participants were actively serving as leaders in their church denomination. Each participant experienced a severe mental health episode that lasted at least two weeks as a church leader. All but one (7%) was married. For leadership titles, 66% identified as a pastor, 55% as a minister, and one as a reverend. For religious affiliation, 33.33% were Baptist, 22% were Methodist, 33% were non-denominational, and 22% were Church of Christ. Only 22% identified their spouse as the primary support. The average time in leadership for this sample of church leaders was 20 years. Below is a brief introduction about each participant. Pseudonyms were used for each participant to protect their identity.

Participants

Abraham

Abraham, the first participant, was eager and friendly to share his experience with mental illness. He was a 35- to 44-year-old divorced African American male who served as a minister in a

Church of Christ church for over 19 years. Abraham also held a second job working in his community. He was a divorced father of one child. His ministry training consisted of a master's degree. He spoke of how being a new minister and leading a church while at the same time going to school, working multiple jobs, dealing with medical issues, and trying to run his household eventually led him to consider suicide. He also had to deal with feeling betrayed by those he had helped. He expressed frustration with the false narrative that pastors should have it all together. His constant pressures made him contemplate suicide on three separate occasions. His life had become so unbearable that he found himself isolated and turned to alcohol and other "immoral" behaviors to cope. He realized he could no longer push himself to uphold the unrealistic image of having everything together. He overcame his battle with the help of close peers and a change in mindset. His support system included family members, friends, members of his church, church leaders, and his therapist. He advocated for pastors to have "outlets" and to take more "sabbaticals" to maintain a healthy and balanced ministry focus.

Rachel

Rachel, the second participant, discussed how she was unprepared to deal with interpersonal care through seminary training. She was a 35- to 44-year-old married White female who had served as a minister in a non-denominational church for over 10 years. Rachel prepared for ministry with a master's degree and seminary training. She did not expect to be placed "on the front lines" at the beginning of her ministry. She had to develop skills in conflict resolution through on-the-job training. She attributed ministers crashing because of the unrealistic and "toxic" expectations the church and pastors placed on being a multitalented "CEO." Her emotional challenges began when she had to take on extra work because the departure of "two key people" overwhelmed her quickly, which turned into panic attacks. She had the added stress of being seven or eight months pregnant and feared the judgment of not pulling her weight because of her condition. She had a history of using mood-stabilizing medications but had stopped taking them during her pregnancy.

The panic attacks concerned her enough that she opened up to her lead pastor that she could no longer pretend all was well and needed to take time off. She was grateful for the non-judgmental support her supervisor and fellow staff members gave during this challenging time. She learned from this episode to maintain active communication with God and was compliant with her medications and meeting with a therapist. She kept healthy boundaries and a positive mindset. Her support system comprised her spouse, other family members, friends, church leaders, and a therapist. Her relationship with her spouse helped her get through stressful times.

Paul

Paul, the third participant, presented himself as confident and self-assured. He was 45 to 54 years old, a married White male who had served as pastor of a local Baptist church for over 19 years. He obtained a master's degree as well as attended a theological seminary. Paul did not think he could be honest about contrary emotions because he thought he would let "people down." He acknowledged the problem of putting pastors on "pedestals" He had the unfortunate timing of taking the new role as lead pastor during the beginning of the COVID pandemic. He had the perfect "cocktail" of "racial tensions" and "political and leadership challenges," all while trying to manage his local church and take care of his family. He saw an adverse change in character that affected how he acted toward his staff and family. When things became too much, he "just wanted to isolate" and felt joyless with thoughts of escaping "anywhere." He fantasized about having a job with fewer responsibilities toward people. He had prided himself on being high-functioning and self-sufficient, but when Paul felt challenged in his inner strength, he had to humble himself to accept professional, church, and peer support. His support system was his wife, other church leaders, and his therapist.

Jonah

Jonah, the fourth participant, readily shared his time when he had succumbed to the pressures and contemplated plans to end his pain through suicide. He was between 55 and 64 years old, married, a White male, and had served as pastor of a local Methodist church for over 41 years. Jonah

obtained a doctorate and a seminary degree. He warned younger church leaders that what he had learned from years of ministry was not having a "savior complex" and that one should know their strengths and weaknesses. Jonah saw the problem with a savior complex and experienced depression during a stressful time in ministry. He was taking on so many tasks that his brain had a meltdown. Jonah decompensated emotionally quickly, leading to thoughts of ending his life. He credited getting help from his psychiatrist and starting anti-depressant medications with keeping him safe from self-harm. His faith in God and taking time for self-care helped him to conquer his dark thoughts. His wife was his primary support.

Amos

Amos, the fifth participant, shared a diverse cultural perspective on mental illness while leading an African church. He was between 55 to 64 years old, a married African American male, and had served as a pastor of a local Methodist church for over 40 years. He obtained a doctorate and ministry training through a theology seminary. His mental health problems started while pastoring a church in the Congo. He felt a heavy burden from people expecting him to solve their issues and felt confused about not wanting to be their pastor. He overcame the struggle of feeling personally responsible for everyone's problems, seeing the importance of caring for himself, and leaning on his family. He recognized the importance of pastoral support and identified his church congregation as the primary support.

Elizabeth

Elizabeth, the sixth participant, was predisposed to depressive episodes because of a family history of psychiatric issues. With the combination of stress at home and trying to help run a local church, she found herself experiencing a severe mental health breakdown. Elizabeth was a 55- to 64-year-old married White female who had served as a minister of a local Disciples of Christ church for over 25 years. She obtained a doctorate, formal music training, and a ministry education through seminars, workshops, and retreats. Unlike the other participants, Elizabeth did not blame issues at

church for her depressive episodes. Elizabeth identified problems at home that impacted her job performance. She sought assistance with the help of her supervisor and urgent recommendations from three healthcare professionals. Elizabeth took a long overdue time to recover with the help of her staff and family. She accepted the importance of taking regular time to relax and enjoy life. Her support system comprised her husband, family, friends, other church leaders, and treating providers.

Hezekiah

Hezekiah, the seventh participant, discussed how the COVID crisis illuminated how far-gone Hezekiah was from his relationships with his wife, church, himself, and God. He was between 35 to 44 years old, married, White male, and had been a pastor of a local Baptist church for over 20 years. He obtained a master's degree and a bachelor's in pastoral theology. The topic of pastors with mental illness was close to his heart before his experience with emotional issues. His spiritual father, an older brother, had committed suicide. Losing his brother to suicide motivated Hezekiah to break the silence and he started speaking unofficially, opening himself to be a shining light for other church ministries. Despite his knowledge about mental illness and after traumatic ministry events, he found himself in the same dark place as other pastors. He became clinically depressed and isolated and contemplated ending his life. He realized the importance of accountability with other pastors to help him stay grounded and connected with those he loved. His primary support was his wife, family members, church congregation, other church leaders, and professionals.

Joseph

Joseph, the eighth participant, was disappointed that church drama did not dissipate when he transitioned from a mega-church to a smaller congregation, causing him to experience severe anxiety and a crisis of consciousness. He was between 45 to 54 years old, married, and a White male who had been a pastor of a local Baptist church for over 20 years. His training and education to become a pastor included an associate and professional degree and a vocational seminary. God led him to leave a mega-church to work in a much smaller church focused on helping people with mental and

substance use issues. The transition was going fine until church attrition started to make him question everything. He felt like a failure, but he tried to use his marathon training to make it look like he was managing his life successfully, but he found that being vulnerable with trustworthy peers helped keep him accountable. His wife, family members, friends, and professional providers were his primary support.

Isaac

Isaac, the ninth participant, revealed confidence in his role as a church leader and was denigrated because of a lack of external validation for his ministry work, which occurred during the off-season. He was a 25- to 35-year-old, married, White male and had been a minister of a local Church of Christ church for over six years. Isaac gained ministry training and education with a master's degree. Mental illness for him was a seasonal problem that occurred every fall. His ministry was working with students so that he would be fully active during the summer, but then there would be a sharp decline in activity in the fall, making him think his work was not valuable. Isaac struggled to accept that he was depressed despite feeling disconnected from God, isolated, impatient with people, and losing interest in his usual activities. His primary support was his wife, family members, friends, and other church leaders.

Solomon

Solomon, the 10th participant, developed suicidal thoughts after dealing with betrayal in his church. He was a 25- to 35-year-old, married White male who had served over 13 years as a minister of a local Baptist church. Solomon obtained training and education with a master's degree. Solomon admitted he had based his "whole performance" on his performance, which caused severe anxiety about external criticism of his work. One close church relationship that turned sour because of betrayal had him questioning life and ministry. He overcame his broken heart by developing a well-balanced life of family, friends, and shared church leadership. His wife, friends, church congregation, other church leaders, and professional providers were his support system.

Daniel

Daniel, the 11th participant, found that being a leader in the church can be very lonely. He tried to shoulder responsibility for running the church but being unable to trust others led to emotional difficulties. Daniel was a 35- to 44-year-old, married, White male who had served over 13 years as a pastor of a local non-denominational church. He achieved his ministry training and education with a master's degree and a vocational seminary. He had been discharged from the military, became a Christian, and felt led to become a preacher. His military training did not prepare him for the challenges of being a husband and father of three children while attending seminary and college, working multiple jobs, and participating in community recreational activities. His mind could not hold up to these pressures, and his wife encouraged him to seek assistance. He accepted professional help and medications to help him maintain a healthy mindset and stable emotions. His wife, friends, other church leaders, and experienced providers were his primary support.

Results

As expected in IPA research, several themes emerged from examining participants' experiences. Themes were identified by analyzing each interview transcript. The analysis produced five major group themes, each with subthemes in Table 2.

Table 2

Emergent Themes

Major Group Themes	Subthemes
1. Training and education did not prepare for the realities of church leadership	1. Trying to uphold the perfect pastor image 2. Becoming overwhelmed
2. The problem of stigma in the church	1. Church Conflicts 2. Fear of job joss 3. Lack of programs specific to pastors
3. Difficulties coping with the overwhelming stress	1. Severe feelings of depression, helplessness, anxiety, and hopelessness 2. Thoughts of self-harm 3. Engaging in isolation 4. Questioning competence and identity
4. The source of the mental illness	1. Biological explanation 2. Stress explanation 3. Spiritual explanation
5. The transition into healing and restoration	1. A change in mindset 2. Accepting peer support 3. The church's role 4. The practice of healthy coping skills

Theme Development

The IPA process, designed by Smith and Nizza (2022) for developing themes, involved completing an initial analysis by identifying themes and subthemes one transcript at a time. The steps were:

1. First, this researcher read through the transcript and listened to the interview audio to refamiliarize the researcher with the participant's words to help structure the participant's experience.
2. From there, while rereading, this researcher wrote initial exploratory notes on the right side of the transcript. This researcher classified the notes as descriptive, linguistic, or conceptual to help "think more in-depth" about what the researcher was identifying in the transcript (p. 35) and kept a separate journal to "bracket" and make notes of this researcher's "reflections" of personal opinions, beliefs, reactions, and thoughts.

3. After initial noting, this researcher developed experiential statements from the exploratory notes to "capture the psychological substance of the text" (p. 39), writing them on the left side of the transcript.
4. Next, this researcher placed each experiential statement into an Excel sheet and MAXQDA to examine the statements for similarities and differences, combine and discard them, and cluster the comments into subsets from which, eventually, the researcher created personal experiential themes and subthemes.
5. This researcher created a table of the personal experiential themes and subthemes with the corresponding quotes that most supported the themes for each transcript.
6. The final step was a cross-case analysis using the manual and MAXQDA methods to organize each personal experiential theme and its subtheme to cluster by identifying similarities and differences to develop the final group experiential main and subthemes.

The five group themes this researcher extrapolated were training and education that did not prepare for the realities of church leadership, the problem of stigma in the church, difficulties coping with the overwhelming stress, the source of mental illness, and the transition into healing and recovery. These five issues are critical in the lives of pastors with mental illness, and proper interventions are needed.

First Group Experiential Theme: Training and Education Did Not Prepare for the Realities of Church Leadership

The first group experiential that emerged was that the training and education these church leaders obtained did not include the necessary elements to prepare them for all the challenges of church ministry. This group has two subthemes: (a) trying to uphold the perfect pastor image and (b) becoming overwhelmed.

The pastors in this study went into church ministry because they felt called by God and obtained their training and experience through seminary or a college degree to become church

leaders. After graduation and the start of their work in local churches, the pastors did not know that the role of a minister is more complicated than presented by their seminary and college training.

Rachel felt disheartened as she did not think her training adequately prepared her to manage her personal and ministry life:

> The expectation is . . . I'm going to teach, and I'm going to lead, I'm going to pray . . . I'm going to be the one administrating and coordinating and training. I think I was less prepared and didn't anticipate . . . the [challenges with] interpersonal care [and conflicts when] . . . seminary . . . training all focused on academic teaching . . . I had one class on pastoral counseling . . . and zero training on conflict resolution.....I was just naïve [about] how much [resolving conflicts] would be a part of my job.

Elizabeth felt the same way, disappointed that education did not adequately prepare her for leading a church. Elizabeth stated, "I think there's much stress there.....That's something that you don't learn. . . . There's not much education ahead of time for pastors just starting.....into ministry." Paul expressed the same sentiment while ministering to others, "Every person brought a new problem to my desk that I didn't feel adequately prepared to handle." Isaac expressed the same sentiment when asked about being expected to solve all problems, "It makes me feel ill-equipped .....I've had training..... schooling, and seminary and years of experience, but that doesn't mean that I know how to handle every single situation." The problem of not being prepared is inherent across participants in describing the beginning of their ministry.

Trying to Uphold the Perfect Pastor Image

This subtheme encompasses the efforts that pastors often make in trying to uphold the unrealistic image of a fully functional, almost superhuman, never failing, problem-solving man or woman of God. All the participants worked extreme hours in multiple tasks governed by internal and external pressures to present a stable, high-functioning church leader. Abraham struggled under the external pressures to fit into the preconceived pastor role, "I didn't know how to turn it off and have

my time ..... That was a major problem because I was on 24 hours a day, 7 days a week, which isn't a good thing." Jonah believed that pastors need to protect an image of stability. Jonah stated, "[Pastors need] from developing a close-knit . . . some trusted friends [because] . . . when you're a pastor ..... if you reach out for help, it's going to get around..... Folks might get the wrong impression, 'Our pastor's cracking up.'" Hezekiah identified church culture as one of the driving forces behind this issue, "I was a pastor . . . [addicted] to peformitnism, which the church loves .....They promote you and foster that toxicity." Daniel hid feeling like a failure behind the perfect pastor image. Daniel stated:

> [It] is our pride as men. We don't wanna admit that we've failed in some way..... and not even a moral failure, just.....failing at anything. I'm the leader of the church, and I'm not doing it well. I don't want to admit it.

Joseph admitted to the falsehood of perfection, "It was hubris on my part.....Look at me. I'm wonderful. I'm great. . . . The other side.....I'm terrible. I'm no good."

Internal thoughts, fears, and external expectations from the church and others drove these pastors to present as having no problems, leading to some devasting consequences.

Becoming Overwhelmed

As time goes on and pastors continue to work around the clock, participate in programs, lead meetings, counsel people, and other activities, all while trying to manage church functioning, and their personal lives, their ability to handle it all starts to crumble. All the participants verbalized feeling overwhelmed with managing ministry and interpersonal relationships independently. Daniel felt deeply about this issue, "I was runnin' in the red all the time." Elizabeth expressed the same "I do know that the ministry can be extremely stressful .....dealing with people in all their situations in life . . . and having a lot [of] being on 24/7, that feeling of not being able to get away." Joseph stated:

> One of the elements of ministry that can be overwhelming..... is the idea that they are always "on," continually having to be ready to go at any moment. . . . There is this conundrum. . . .

> It's a vicious vortex.....Many [church leaders] can find themselves spinning outta control. Still, they don't know whom to go to ..... or talk to because they're the ones that are supposed to have it all together.

Solomon felt helpless:

> Man, I just can't control—I don't have any power over this. . . . It really did scare me ..... cuz I felt weak . . . , but then it just made me mad..... The temptation, especially at our church, is we're evaluated on our activity, how many events, how many people are reached. It's kind of . . . unwritten; as long as you're not complaining about it.....then you're doin pretty good.

Jonah lamented the push to sacrifice more of himself:

> I might work a 12-hour, a 15-hour day, but if I give in to the temptation ..... there's always someone else that I could pray for . . . reach out to . . . [write] another note.....There's always another cause that I can educate myself about, and I can just get burned out for what seems like very good reasons. I was just caring ..... trying my best, and of course, we know that [at] the end that doesn't bode well. It results in burnout or resentment, or a sense of failure.

Paul became despondent, "I think [dealing with administrative pressures] led me to this really dark place where I didn't enjoy what I was doing anymore..... All I was doing was putting out fires, and I wasn't even doing that successfully."

All the participants expressed this subtheme. Taking on too much for too long eventually led them to a dark, lonely, and scary place. The absence of realistic training in the educational and seminary programs for aspiring church leaders was an issue that all the participants had to overcome.

Second Group Experiential Theme: The Problem of Stigma in the Church

Despite the growing public knowledge and acceptance of mental illness and the advancement of scientific interventions, many churches in the United States still refuse to accept any secular ideology about emotional or psychological concepts. The church's refusal of mental illness makes it

difficult for pastors to admit problems, seek help, and accept help, when they come to a breaking point. The second group experiential theme had three subthemes: (a) church conflicts, (b) fear of job loss, and (c) lack of programs specific for pastors.

The participants identified conflict within their church as a part of the stress contributing to their mental and emotional breaks. Several participants were shocked by being betrayed by those they trusted. Abraham was dismayed by his congregation's lack of support: "I felt a lot of church hurt from [many] people who had turned on me." Daniel was also stunned by being let down by some in his church:

> When we share things in confidence . . . and come to find out the church person gets hurt or has "church hurt" . . . and they end up hanging your dirty laundry and using it against you . . . it makes it very difficult for ministers to want to have anyone that they can trust.

Amos discussed the problem of stigma in the church, "Most of us don't preach about these things, it's a— They think it's a kind of taboo, it's taboo." Solomon was also hurt by those he thought he could trust, "The betrayal part, man, that's a hard emotion." Paul held the concern for duplicity, "The fear for me as a leader is that [if he shares that he is having mental challenges] people will use this against me." Jonah was bothered by the critical judgment of people toward pastors, which can cause deadly consequences. Jonah stated, "for many people, as a pastor, you'll be elevated in people's minds . . . whether in terms of one's morality, knowledge, or having it together or being closer to God [and trying to uphold this unrealistic expectation] is very agonizing!" Hezekiah struggled with the cultural expectations of his church, "When you're a spiritual leader," and when you develop some psychiatric issue, some "confused Christians literally think it's a sin." Elizabeth was hurt by stigma as it played a part in suicidal pastors not seeking help. Tearfully, she replied, "I know [about pastor suicides], and if they don't feel like there's a safe place for them to share their failings or weaknesses, then sometimes they just [give up]."

Church Conflicts

The issue of problems between members and staff in churches around the world is all too common with hundreds of books, movies, and television shows that portray backbiting, gossip, inappropriate relationships, and often illegal activities. Church conflicts are not a new phenomenon, as concerns in the church are evident in the Bible. For example, in the New Testament, 1 Corinthians 6:1-8 (*King James Study Bible*, 1988/2017), churches are admonished to address these issues correctly, contrary to what a true Christian church should portray.

Amos also felt unappreciated, "I felt disappointed like people are exploiting me . . . exploiting my kindness, my openness." Rachel also felt overwhelmed by external demands, "Feeling pressured to perform even though I felt like was in a place where I was depleted and yet still being asked of and leaned upon that was just creating much stress." Elizabeth was frustrated about the conflicts within her church. Elizabeth cited that one of the most significant issues with returning to in-person church services was dealing with "lots of stress working with people" because of differing opinions about ministry processes, leading to many "unpleasant" emotions. The loss of being able to unite in harmony although different cultural beliefs was disappointing. Hezekiah also felt entangled:

> Ministry is just a relentless and unforgiving job. There's just a short list of other jobs that invade your life to the degree that ministry can. So that depletion, that idea of pouring out without pouring in, means I have to do a magic trick, constantly I was in a profoundly depleted place emotionally and spiritually. I wasn't taking care of myself physically.

Daniel had extreme disdain for church members who implicated a lack of faith as the reason a pastor may struggle emotionally. Daniel stated, "The next person that comes up [to] me and says I need to read the Bible more and pray more, I'm gonna punch 'em in the throat because that's not it. If that was the answer, then I would be done..... I would already feel better." Unfortunately, conflicts within the church continue to plague church leadership.

Participants discussed the conflicts within church relationships as surprising and heartbreaking. The participants felt unprepared for miscommunication, misunderstandings, and unrealistic expectations they would have to navigate in interpersonal situations. The overwhelming burdens of church ministry were prevalent throughout the interviews.

Fear of Job Loss

No one wants their mental instability used as a justification for being let go from a job. These participants did not feel any different. Joseph did not want to admit he had any internal problems, "[If] I say anything, they're gonna punish me. I'm gonna lose my job . . . my tenure . . . my license." Paul too feared his job was in jeopardy if he admitted he had mental health struggles. Paul stated:

> The fear for me as a leader is that people will use this (him feeling overwhelmed from ministry) against me . . . other people on my leadership team thinking that I'm no longer effective and can no longer lead the team, and therefore maybe they try to take over leadership.

Fear of career loss was real for Daniel, "When I bottomed out and asked for help from my church leadership . . . part of the reason ministers can't ask for help is because it's not safe. If they admit that they have a problem then they're gonna be . . . dropped from the ministry. ..... I would've been fired." Abraham feared that being vulnerable would negatively interfere with his job. Abraham stated, "I feel like I can't open up to anyone because then they will see my flaws and issues. If they see mine, then they may not allow me to help them. . . . [I'll] lose everything. .....They [his church] would let me go."

For several participants, an essential motivation for hiding their mental struggles was the concern that they could lose their careers. The pastors were aware of other pastors who lost their jobs because of revealing a mental disorder. The ongoing stigma in many churches hindered church leaders from being willing and honest about mental issues.

Lack of Programs Specific to Pastors

Across the United States, there are hundreds of schools and seminaries to train would-be pastors. These participants' schooling and training did not prepare them for the realities of church leadership, and when the pastors were deep into their work in their ministries, where to turn for help was challenging. Joseph lamented that pastors can "succumb" to trying to uphold the perfect image, which leads to a:

> vicious vortex . . . [where] pastors and ministers can find themselves spinnin' outta control, but they don't know whom to go to. They don't know whom to talk to because they're the ones that are supposed to have it all together.

Rachel was unaware of resources to help her. Rachel stated, "There wasn't any specific support. . . . No one had direct experience with what I was going through." Daniel blamed church hurt for making pastors "guarded" and making things "very difficult" for ministers to want to talk to "anyone we can trust that we can share our true struggle with." Abraham also did not readily see assistance:

> I would say most clergies are depressed..... We're the ones that people come and talk to, but . . . we don't go and talk to anyone else to try to help alleviate all the things we are taking. . . . We consume everyone else's problems..... We don't have a healthy outlet.

Amos believed that pastors isolate themselves because they have to present as well-off, "Some think I'm different. I'm the leader.....I'm a man of God," and pastors "don't have somebody with whom they can share [their problems]."

Although there are programs across the United States for all mental health disorders, very few are specific to religious leaders. These participants struggled in the unique and challenging pastor role, and when it came time to do something about their growing discontent, some found themselves blind to helpful resources.

Third Group Experiential Theme: Difficulties Coping with the Overwhelming Stress

The third group experiential theme had four subthemes: (a) severe feelings of depression, helplessness, anxiety, and hopelessness, (b) thoughts of self-harm, (c) engaging in isolation, and (d) questioning competence and identity. Pastors are not superhumans; they are normal humans who can become stressed, burned out, and suffer emotional problems. It is a false narrative that pastors are above reproach and have it all together all the time.

Severe Feelings of Depression, Helplessness, Anxiety, and Hopelessness

All participants experienced classic mental health symptoms that negatively impacted their lives for a short time. Paul denied ever having any thoughts of ending his life. However, he did suffer severe feelings of hopelessness and helplessness, "Fortunately, suicide was not ever a thought that I had, but I would often [think] if I could just fill my car up full of gas and drive anywhere..... I lost joy in things that would normally bring me joy." Paul replaced joy with "just sadness, discouragement ..... I felt numb on the inside." Elizabeth felt blindsided by her condition, "When those depressive episodes hit me, it's like a shutdown emotionally.....I'm very emotional for no reason..... I'm crying." Hezekiah struggled with painful feelings of emptiness, "I was in a profoundly depleted place emotionally, spiritually. I was not taking care of myself physically..... I had a blind spot..... I was just unaware of how bad it was [until] the panic attacks definitely scared me." Daniel described his "mental health journey" with "the two biggest words—helpless and hopeless." Abraham did not understand what was going on with him. "My primary care physician who did testing on me said I was highly depressed." Solomon also experienced depressed emotions, "I felt sad .....and thought if this is [a] reality of ministry, I don't want to be in it." Jonah described his experience of becoming overwhelmed, "It was the straw that broke the camel's back or the crack in the dike that resulted in a flood .....My brain worked different[ly]. I was sad. I was anxious. I didn't know what was wrong."

The participants shared their experiences with emotional and mental instability. Many participants noted the negative emotions of depression, anxiety, and hopelessness, the classic symptoms of major depression. Although there are resources for psychiatric disorders, these participants could not access them in a preventive manner.

Thoughts of Self-harm

Six pastors willingly admitted they thought of taking their lives to deal with the emotional pain they were suffering. Joseph explained that when he was experiencing overwhelming anxiety and hopelessness, his mind became darkened, and he began to think, "Ya know what, it may not be a bad thing just to go back to sleep and not wake up." Going through trauma is linked to suicidality. Hezekiah found himself evidencing this phenomenon. Hezekiah suffered multiple disturbing events while working in the church. Hezekiah stated, "I walked through a series of traumatic ministry events that spiraled me into a really-really dark place. I spent about nine months . . . with severe clinical depression and had nine months of oppressive suicidal ideation." Solomon also felt profoundly hurt from being betrayed by church members with whom he had what he thought was a mutually beneficial relationship and had supposed, "The betrayal . . . I can't believe I've watched their children and ministered to them so well, and this is what I get for it..... Maybe they'll feel really bad if I commit—if I hurt myself."

Daniel's negative evaluation of his role as a leader in the church and his family felt seduced by thoughts that he no longer mattered:

> No one's gonna miss me if I'm gone..... I'm more of a burden right now than a help. All I'm doin' is causing people problems, and so if I wasn't here, my wife and kids would be much happier because [of] the stress I'm causing them . . . is too much. It's my fault .....I'm helpless.....I can't fix it.

Abraham was going through severe tribulations, medical, church, and relationships that made him want to escape through deadly means, "I was literally about to kill myself, and a preacher friend

popped up . . . and talked me off the ledge." Jonah stated that during his episode, "I felt like I was going crazy .....Within a week, I went rapidly to complete sadness, despair, and even suicidal thoughts."

These participants flirted with the thought that taking their lives would be a good and permanent solution to the problems they were facing but were able to overcome this mindset thanks to a change in perspective, their faith, trustworthy peers, and supportive family.

Engaging in Isolation

Eight participants engaged in isolating behaviors, not wanting to connect with friends, family, or church members for various reasons. Elizabeth described her depressive episode, "I'm like in a cocoon . . . and feel numb . . . ya know, separated." Isaac found himself "wanting to be alone .....just wanting to withdraw and not really [wanting to] talk to anyone, except for my wife." Joseph blamed giving the devil a foothold for his withdrawal from society, "I isolated from people because I was the one who had to have it all together." Hezekiah felt "profound feelings of aloneness." Daniel had the same feelings as Hezekiah. Daniel grieved and stated, "Ministry's a lonely place. Uh, leadership is a lonely place..... because we can't share all of our stuff with other people." Abraham "felt alone" and "isolated." Amos saw isolation as a way to cope, "I'm going to stay home.....I don't want anybody to come here..... I'm not going to talk to people anymore." Paul isolated himself because of the stress of dealing with other people's problems. Wanting to isolate during a mental health episode was typical behavior. These participants struggled to see any outlets; they felt alone.

Questioning Competence and Identity

Seven participants questioned their calling as ministers and their ability to be influential church leaders. Amos stated, "I made a mistake. I should not be their pastor or minister. I should do something else. This is too much." Solomon felt terrible, "I'm a failure." Isaac was disappointed after years in ministry, "My identity for the last 12 years was I going to be pastor [but] when I am down and when I'm questioning if I wanna be a pastor, my identity, my ego takes a hit." Guilt and shame

plagued Hezekiah, “There were profound feelings of hypocrisy . . . which led to feelings of failure . . . and then feelings of profound shame.” Joseph felt flabbergasted that he could not “just fix it,” and when things did not turn out how he wanted them to, “It reinforced the false belief that I wasn’t qualified to do [ministry work].” Rachel was trying to perform to the best of her abilities. Eventually, she fell under external pressure, making her feel “inadequate” and like a failure and “incredibly weak” . . . and “then just questioning . . . my calling.” Daniel had self-deprecating thoughts during his episode, “I’m a piece of crap.” Abraham struggled with his self-image, “I’m not good enough .....I even lost my zeal to preach. . . . I can’t lead God’s people .....because I’m so messed up.”

Not all participants questioned their competence or identity. Instead, the ministry role challenged pastors in other ways. Elizabeth felt competent and confident. Elizabeth stated, “I don’t think I’ve ever had any negative thoughts about myself as a person or my worth .....I would have thoughts that I am in the wrong place or doing the wrong thing.” Neither did Solomon, who was very confident but had just been “really” scared because he felt “weak” and could not control what was happening. Jonah did not question his abilities. Instead, he was humbled by his mental health episode, “Instead of being the one who had to be in charge or have it all together, I realized I’m just another child of God in need of God’s help.”

These participants had to deal with disappointments and unsuccessful projects and started to doubt their calling and abilities to lead the church. When the participants looked in the mirror, their egos were challenged, leading to despairing thoughts. The participants’ experience with emotional issues led them to redefine their church leadership role.

Fourth Group Experiential Theme: The Source of Mental Illness

The fourth group experiential theme had three subthemes: (a) biological explanation, (b) stress explanation, and (c) spiritual explanation. Most of the participants struggled to define mental illness. Pastor Abraham stated, “Mental illness is just, golly, [something]. I’ve never just really thought about defining it.” Hezekiah expressed the same sentiment, “That phrase [mental illness] is a

bit of [a] struggle for me because I think [many] times, we mean emotional illness, and then some of the times we actually mean spiritual illness, and sometimes we mean relational illness." Isaac answered the question, "I think mental illness is kinda the broader term for um, of-of a variety of different, uh, I guess conditions.....I don't [know] if this is right or not."

Although there are established definitions of mental disorders by the APA's DSM-5, some of these participants struggled to give a comparable description of mental illness. During the interviews, some participants made hesitant repetitions of "ums" and made apologetic statements as if concerned about providing the correct answer. The Bible says that men perish for lack of knowledge, and these participants' lack of understanding had a part in prolonging and delaying timely interventions during their mental health episodes (*King James Study Bible*, 1988/2017, Ho. 4:6).

Biological Explanation

Six participants attributed their mental health episodes to a physical/biological condition. In one Bible story in First Samuel (*King James Study Bible*, 1988/2017), about an evil spirit sent by the Lord to harass Saul, Jonah stated, "The way I read that, I think he was probably bipolar..... He shows evidence of mania and then of deep depression and hopelessness." Elizabeth's belief about what causes mental illness was like Jonah's: "My understanding of mental illness is that it's like other illnesses of the body. There are chemical imbalances, and material things can just cause them ..... I definitely believe that it is a biological illness." Daniel saw mental illness symptoms as the body's "check engine light," indicating that something is wrong "in the brain or emotions" that needs to be fixed. Solomon equated mental illness to a "chemical imbalance." Joseph blamed issues with his brain functioning, "Essentially my hippocampus was hijacked my amygdala [which] had hijacked my brain so my prefrontal cortex can't come back online." Hezekiah acknowledged a family history of suicide and believed this influenced his mental health problem. He stated, "I think some biological tendencies [were] a huge contributing factor."

Stress Explanation

Becoming overwhelmed by life stressors can contribute to developing a mental illness. Still, like the biological explanation, some participants attributed emotional issues mainly because of conflicts in life and relationships. Solomon believed that what happens in a person's environment can negatively affect a person's mental state. A checklist that was supposed to help keep him organized turned into a serious burden that fed into Daniel's severe anxiety:

> I write checklists ..... When those checklists get too long, I become overwhelmed. Then I get anxious ..... Then it [becomes] this cycle like a needle going back and forth between a meter back and forth between two things . . . getting stuff done and being anxious ..... [but] eventually I get stuck to a point where I don't want to do [anything].

Hezekiah settled on this definition for mental illness, "Mental illness is the result of some sort of dysfunctionality because of past emotional wounds, physical trauma, relational wounds." Difficulty dealing with the problems in life can contribute to emotional instability. Abraham stated, "Mental illness is when someone has something going on their life where in their mind, they're not able to cope or handle things ..... in a normal way."

Amos felt overly burdened by ministry work. Amos stated, "Because of the too many problems, too many problems going on, so I'm tired in my mind." Elizabeth also wanted to give up because of all the stress, "The only thing I can remember is that I just can't do this anymore." Jonah described being diagnosed with severe depression as a result of tremendous stress.

Spiritual Explanation

Only three participants mentioned without prompting their belief that mental illness could have a spiritual cause. Joseph had this to say when asked what he believed mental illness is, "I say that mental illness limits our capacity to live a life of wholeness as designed by Jesus..... and with His spirit in us. . . . We can endure all things ..... but if you don't have His spirit, we're left to our own

devices . . . spiritually dead." Mental illness is more than just biological or stress-related conditions. Rachel saw mental illness as a related issue:

> As a Christian, I sometimes think that mental and spiritual will be separate. Still, I think they're interlocked, so if you're having spiritual symptoms like depression, anxiety, or sadness, sometimes it's linked to that mental health issue.

Paul defined mental illness from a biblical perspective, "I'm sure that there's a clinical definition, but I would say that for me, as a believer, mental illness would be that when your soul is not as it should be." One participant even went as far as stating that the Bible needs to be "updated" in the areas where actual spiritual beings are mentioned: Jonah said:

> It's my understanding and my reading of scripture that there is some updating or some interpretation that is needed. For instance, in the case of King Saul, it is said that an evil spirit would visit him. By my— The way I read that, I think he was bipolar.

The participants had different opinions about what they believed contributed to their emotional breakdown. Mental disorders indeed have a biological component, and constant stress can negatively affect one's emotions, but interestingly, only a few participants talked about the spiritual impact.

Fifth Group Experiential Theme: The Transition into Healing and Restoration

The fifth group experiential theme had four subthemes: (a) a change in mindset, (b) accepting peer support, (c) the church's role, and (d) the practice of healthy coping skills. All the participants felt abandoned in a valley of darkness, unable to see the light or find a way to escape from their emotional pain. Abraham expressed what keeps pastors from seeking assistance, "I think a lot of us are in denial that we can't [have problems]. We're the preacher. I can't have mental health issues. I can't have problems. Yeah, you can." When it looked as if there was no hope, they overcame the strongholds of fear, shame, and hopelessness to take the necessary steps for recovery.

A Change in Mindset

A person's lifestyle is established by how one thinks and reasons in their heart. A person's life experiences and life are either stable and healthy or dysfunctional and unhealthy (*King James Study Bible*, 1988/2017, Prov. 23:7). All the participants realized the way they thought was keeping them bound in adverse psychological and behavioral processes. A part of overcoming the emotional health episode was shifting their mental processing of situations. Abraham became hopeful thinking about his future, "I believe I have [a future]. I think it's totally different than what I looked for in a future prior to accepting that I had mental health [issues]." Rachel realized that thinking she had to be responsible for everything was unhealthy:

> [I changed] my theology and realize[d] I can love God and do what I [am called] to do and be faithful with what he's given me [without overperforming] and [I can take care of] my body and mind. So, changing some patterns of thought definitely has helped.

Paul's mind no longer focused on hopelessness, "I feel like I have life again, a little bit more optimistic, futuristic." Amos no longer considered quitting the ministry because of the ongoing trials, "I don't want to give up. It's not easy, but I don't want to give up the future. I will keep doing what I'm doing, even though it's not easy." Elizabeth increased awareness of the importance of standing by priorities, "I don't feel negative about taking time to do nothing of importance because I know I need that for my mental health." Joseph saw that he had a choice about what he should focus his attention on:

> I call it the ministry of presence, being present in the moment you are. As opposed to having my mind wondering about "Well, I should be doing this, and I didn't do that. Oh my gosh! I forgot to do these types of things." It's entrusting it to the Lord and being present in the moment.

Hezekiah woke up to the truth about his mental health problems:

> It took them to help me see reality. . . . I think I had a blind spot to how bad I was doing I believed, "Oh, I'm not hurting as bad as everyone is, so I just have to keep pushing forward,"

> . . . until, because of their loving shepherding, they let me pull away and actually sit long enough to actually hear my soul. I just was unaware of how bad it was..... I rationalized my unhealth.

Isaac was the only participant with a troubled mindset, "I think some days, I feel stuck . . . where I am .....and that leads to more stress because I don't have a next step or a way to pivot, and so, I feel like I'm stuck." Solomon kept charge of many responsibilities, "My coping rules now is I've [got] the mental part, I've got the respite, I've got good rhythms, the balance between abiding with Christ and doing [good works] for God." Daniel was excited about the change in his thinking process, "I've got a positive outlook. I'm optimistic I intend to make my family a priority over the ministry."

Accepting Peer Support

Leaning on others is an essential aspect of maintaining a balanced lifestyle. Abraham stated, "I have accountability partners . . . two other clergies we talk two or three times a week.....We stay mentally healthy." Rachel was grateful for support from her supervisor and staff, "[We] need allies, partners who get it, who will pray, help you, point you to counselors..... people who realize the church isn't going to fall apart because you fall apart."

Paul no longer feared being vulnerable:

> Our board has come along ..... We have a monthly meeting [where] they want [a] report on how I'm feeling and doing..... and my willingness to involve people and give them permission to check in on me has been really good for me.

Elizabeth felt blessed to have non-judgmental assistance from her work peers, "I had the luxury at this place to have a supervisor and staff that were very supportive and .....they knew of my condition . . . so they were very understanding."

Jonah saw how confiding in trustworthy peers helped him maintain a stable emotional attitude. Jonah stated, "For me, having the wisdom to surround myself and develop that cadre of

people, whether it's colleagues in other churches or those mature enough to handle [my issues], that's pretty important!" Amos found encouragement from close relationships in his church, "My friends [from the church], they talk to me . . . provide advice when see things are wrong [to] save my life." Hezekiah welcomed the accountability of his peers to help him:

> I have a list of guys in my life who are pastors of other churches .....We understand each other, and we're daily in touch, and when it's a dark day, I'm gonna speak that out.....living in daily awareness and openness to be questioned and be held accountable and [open] to [loving confrontation].

Joseph looked to his male counterparts to keep him on the straight and narrow:

> I have some real quality relationships with other men that I know I can truly say that we would go to war with each other .....I know their faults; they know mine. We love each other anyway.

Isaac felt like he had people he could turn to if needed, "I have the trust and confidence of people around me in my workplace that I could [ask for help from]." Solomon accepted the need to be open to peers for stability, "I'm a part of a leadership team .....and we talk about our problems, and it's very therapeutic." Daniel was grateful for his supportive staff, "Thank God put me in a perfect place with the perfect staff and elders that surrounded me."

The Church's Role

The church plays a pivotal role in the lives of its church leaders. Four participants viewed their church as fully supportive, while seven revealed ongoing cultural challenges. Abraham's church was very active in his life, "The congregation is very supportive. They set funds aside for me to either pay for therapy [or other recovery activities] and they make sure I go and do [these activities]." Paul was assured of his church's positive stance on mental health, "Our church, we're very compassionate towards those struggling with mental illness. . . . We have our own counseling center .....We recognize that people are broken [but] it's okay to not be okay." Unfortunately, not all participants

had a beneficial experience within their church. Rachel was discouraged by ongoing issues in her church, “As far as church [a support], it’s hard to know. The further I get in church leadership, the less friends I seem to have at my church, so I’m struggling with that a little bit.” Jonah had a mixed reaction to his church’s supportive efforts:

> In the Methodist tradition, we have what’s called the Staff Parish Relations Committee. They guide and uphold as well as evaluate [a pastor’s status]. I’ve got some healthy and authentic people whom I’ve been upfront with . . . but there’s always the question, “Are we letting what’s been suggested work?” Every staff member has somebody they can vent and stay in touch with. It works well . . . but sometimes they don’t [because] some employees [including pastors] get frightened and begin to withhold information because of fear of being “embarrassed” because of not upholding the stable pastor image.

Elizabeth had problems at her church:

> I was very unhappy in the church [because] they got a new senior minister who just made life miserable. . . . It was so bad that I couldn’t even stay in the worship service sometimes.....I couldn’t be in the room hearing that that preacher was preaching. It just was sickening to me. My voice wasn’t being heard at all.

Isaac’s experience with church support was also mixed:

> I’m at a medium to large church and there are probably one-third to two-thirds of the people that I do not know. So, I don’t feel like the whole church helps ..... However, if I had specific needs and requested those needs, I do think that at least a handful of our church would step up to meet those needs.

Solomon was troubled over ongoing conflicts within his church, “The church is complicated. There are good parts, and there are bad parts.” Daniel was disappointed about ongoing issues in his church, “I don’t think my future is to stay here for as long as I can because I don’t think I can operate in a [church] culture where it’s too [much] red tape, bureaucracy, [and] run more like a business.”

Amos's church is overall "friendly," but he is more supported individually. Hezekiah appreciated that his church culture had become more supportive of mental health issues, "I was totally honest with my congregation about where I had been . . . and our culture was shaped towards more holistic, spiritual health." Joseph's church pushes the mental health issue to the forefront. Joseph stated, "The environment I'm in today is one in which mental health issues are not avoided whatsoever; they're addressed by our senior pastor from the pulpit."

The Practice of Healthy Coping Skills

All participants established better ways to cope with stress. Setting boundaries was necessary, as was keeping to priorities. Abraham established a rigid boundary for self-care:

> One thing I do now is every day from 12:00 to 1:30 that's my time . . . where I want to sleep, read a book, go get a massage, whatever. It doesn't matter; It will be my time, and I won't budge that for anyone, for anything.

Rachel was "in a much healthier place" because she "imposed boundaries" and took extra time for rest and recovery. Paul accepted that he would not be able to please everyone if he wanted to maintain a healthy lifestyle. Paul stated, "Disciplining myself, I realized I would rather disappoint somebody" and not feel compelled to give up time for personal care because ignoring self-care would lead him "to be dead or depressed or discouraged." Jonah saw how detrimental overworking was on his mental health, "I've made self-care a priority."

Amos was one participant who did not engage in a typical self-care plan, "[Self-care], that's not easy. I don't know. . . . I'm just sharing with my wife, sometimes with my kids . . . go outside, play, watching football, watching kids play." Elizabeth no longer felt bad for engaging in self-care activities, "I used to feel guilty about [taking time for fun and relaxing pursuits, now] I think this is mental health, this is taking good care of myself." Hezekiah's self-care was to stay actively involved with his pastor peer group, "My daily routine in battling depression is living like I'm a sheep [among peers with authority] "to look me in the eye and then ask me how I'm doing." Joseph is another

participant who sees engaging with people as a main coping strategy, “I have an open forum and relationship with a couple of guys. We get together every single week and we sit and talk about life in general . . . and that helps.” Isaac has an idea of what helps him stay grounded, even though he is not as consistent with fellowshipping with his support, “In those low times, [what] brings me out is hanging out with friends, being in a relationship, having fun, and catching up playing games.” Solomon adhered to an active schedule prioritizing self-care, fun, his family, and church, “It’s prioritizing for me. I give my best energy to my marriage . . . then I regularly walk . . . decide whether to answer text messages . . . pray for church leaders . . . have some fun . . . and [do ministry work].” Daniel relied on professional help and working out to maintain a healthy mindset, “I take anti-depressant medication every day. I see a counselor on regular basis.....I see a psychiatrist every six to eight weeks.....and exercise is one of the most important things that helped me.”

Research Question Responses

RQ1: What are the lived experiences of church leaders with mental illness?

The experience of church leaders who have developed mental illness during their service is one of the overwhelming challenges with trying to serve their church and their families but struggle to do so because of many different factors. Hezekiah expressed his frustration, “Ministry is just a relentless and unforgiving job. There’s just a short list of jobs that invade your life to the degree that ministry can.” Rachel blamed unrealistic ministry expectations, stating, “There’s just a lot of levels of toxic expectations that [make] pastors [believe they] are supposed to be CEOs, incredible teachers, and great pastoral caregivers. . . . It is the pressure that the church creates and that we create .....it’s just not tenable.” Daniel expressed the unrelenting process of church ministry leading to burnout and emotional turmoil, “We’re in the grind every day.” Amos sacrificed himself to help others, but the help was not reciprocal, “I’ve been working with these people more than 30-35 years.....I went through many problems. . . . I felt disappointed ..... like people are exploiting my kindness, my openness.” Jonah expressed the challenge of ministry work. Jonah stated, “Working seven days a

week . . . pastoring, pastoring, pastoring, working, working, working, and then collapsing . . . emotionally just carrying around all this weight of the people that you care about..... There's going to be a physical price to pay one way or the other." Paul discussed the duplicity of the pastor's role, "I think [pastors being stressed, anxious, and depressed] is a real issue with pastors and leaders in the church because of the environment; working in the church is difficult, but at the same time, it's also rewarding." Elizabeth confirmed typical church leadership. Elizabeth stated, "I do know the ministry can be extremely stressful." Abraham found himself trying to juggle too much. Abraham stated, "Just the pressures of being a young minister, going to school, trying to work on a doctorate, everything [led to]..... things I know I shouldn't be doing." Joseph had felt led by God to transition to a "smaller congregation." Still, this move led him to question this decision as well as his developmental symptoms, and he thought, "I made a mistake. . . . I thought I had failed .....There was a moment I woke up about two a.m. and thought I was dying." Isaac's mental issue was based on the level of activity his ministry was experiencing. Isaac stated, "I've experienced more of a seasonal depression. . . . My ministry runs full on during the summer and then slows down during..... the fall, so because of [the decline in ministry activity,] I get into this kinda funk ..... not feeling needed." Solomon's mental health trial was precipitated by church conflicts, "The only time I've ever wanted to harm myself [was] because of something that happened at the church ..... I remember feeling so terrible because of the broken relationship."

These participants experienced mental and emotional pain in working with people, dealing with betrayal, and excessive work that no rational-thinking person could deal with successfully before becoming burned out.

RQ2: What were church leaders' experiences with help-seeking during their mental health episodes?

Some participants took the initiative to seek professional help on their own; others had to have intervention from friends and family that instigated their seeking of treatment, and a few sought to

handle their issues without any outside assistance. Although Hezekiah was aware of counseling services at his church, he did not instigate them on his own. It took outside interference:

> Our ministry values holistic health and has a full-time licensed counselor [who] I did not tell about the panic attack. Still, he saw enough signs of unhealthy that he went to our board and said, "I don't think he's [the participant] doing good. We need to get him some help."

Daniel believed that pastors could end up in a stuck place:

> We get caught in that trap [of overworking], and we can't ask for help. We feel like we can't ask for help. I felt like I couldn't ask for help, and I think that happens a lot in ministry, and the further you go up the chain . . . you get siloed.

Daniel also had to have his wife's encouragement to get help because when she told him he should seek professional help because of what she was witnessing in his behavior, Daniel was distraught, "God, why? . . . There was no way I would have said I'm depressed." Abraham saw through a suicide attempt. He stated, "I had the gun in my hand, but the gun jammed . . . so I went and got help." Elizabeth accepted the need for professional help, "I have been at this position in this church for 13 and half years, and I have had a couple of . . . depressive episodes, and [during] one of them, I was going through a medication change." Solomon received support from his supervisor, "It's one of the few like 'emergency' type of things I've ever had to have my supervisor come to the rescue."

Jonah felt stressed to the maximum, which led to a severe depressive episode. Jonah stated, "It got so bad that I got myself in to a psychiatrist and was diagnosed and got some medication..... The experience of being with the psychiatrist [and] ..... being told, oh, this what I think has happened,' kinda kept me hanging on." Amos discussed the cultural differences that dictate what type of help a person seeks. Amos stated, "In [one country], we don't go to a [traditional] hospital or see a doctor. . . . The older people—70, 80, 65—they are our psychologists. We go to see them, talk to them."

Three of the participants did not seek any help outside themselves. Isaac did not seek professional, family/friends, or other external assistance. Isaac stated, "I've just said yes to any project . . . just to keep me busier . . . just to try to fill some void of emptiness . . . [or] lean into some hobbies . . . finding ways to relieve stress." Joseph dug in his heels, "I can fix it. I can manage this." Paul also relied on positive motivation, thinking, "I just kept telling myself maybe tomorrow will be better .....I'm going to discipline myself out of this." Rachel initially tried handling her growing emotional instability on her own, but the symptoms became overwhelming, "I felt stuck ..... I didn't want to be honest with my boss. . . . Eventually.....I started having panic attacks daily, forced my hand.....and at that point, I was really honest [and] went to our lead pastor." Knowing what to do and where to turn for help can be difficult in a mental health emergency. These participants had different ways of healing during their episodes, but all overcame their issues.

RQ3: How were church leaders' relationships during the mental health episode?

All the participants identified trustworthy peer support as a critical component of their recovery and maintenance of a healthy lifestyle. Joseph credited his support system as a vital component in his maintenance plan, "I'm not saying that there haven't been moments in which I have felt heavy, but I have somebody I can go talk to." Solomon had the support of his wife and his church supervisor during his experience. One night, Solomon called his supervisor, stating, "I really need to meet with you. I'm thinkin' about harming myself, and I need some perspective." He also depended a lot on his family, "My wife was with me, and this is another reality of pastoral mental illness, is your family. They bare that burden more than the church does." Rachel identified healthy boundaries and priorities, and her "staff values are Jesus, first, family second, work third" and "that has helped me immensely because I feel..... I can be more balanced." Amos leaned on his close relationships, "Sharing with my wife, sometimes with my kids, they are kinda back up to me, [I] rely on my family." During Abraham's time of severe life struggles, he had the support of close peers and professional interventions. Hezekiah relied a great deal on his peers and professional help, "I

heightened my relational accountability to my brothers who are pastors . . . [and] I got with a licensed counselor who's a believer." Paul had a reprieve from his internal suffering with his spouse and close friends when they all "went on a retreat . . . We laughed for about four days straight I told my wife, 'I don't think I've laughed in over a year.'" Isaac depended on his wife during his mental health episode. She was the only one he believed he could "talk to."

Jonah had his family but saw the importance of peer support. Jonah stated:

> You can trust and lean on and having the wisdom to [be surrounded] and to develop that cadre of people whether it's colleagues in other churches or those who are mature enough to handle this [Jonah's mental health diagnosis] that's pretty important.

Unfortunately for Elizabeth, problems in her personal life were more conflicted, "I was okay to be away from the stressors, which weren't my ministry that was stressing me at all. There were home situations that were stressing me." Daniel's wife supported him when his mind succumbed to stress. Whether a peer, a spouse, or a friend, social support was a key component of helping pastors get through their emotional and psychological problems.

Summary

This chapter presented the experience of 11 participants from the Dallas/Fort Worth cities who shared a time in their lives as church ministers and were dealing with a mental episode while trying to be the best leader they could be. On average, this group of pastors had served in their local congregations for 20 years. The researcher used the narrative form to describe the participants' quotes of their experiences. Data analysis identified five major themes: training and education did not prepare for the realities of church leadership, the problem of stigma in the church, difficulties coping with the overwhelming stress, the source of mental illness, and the transition into healing and recovery. The data sources to ensure reliability and validity were the interview transcripts, member checking, purposive sampling, reflexive journaling, and thick descriptions. The researcher identified the five themes and their subthemes through a time-consuming and meticulous data analysis process.

The research addressed the three main research questions in this chapter. Participants described their time in ministry as highly stressful, contributing to their development of mental health symptoms during the psychiatric episodes. Help-seeking was either taken by self-will or instigated by outside forces, primarily by peers or family members. Although the participants went into ministry with pure hearts to serve, they were unprepared to deal with the inner strife of people's problems. They had to overcome stigma, betrayals, and fears of being seen as incompetent or forced to relinquish their church leadership. The unrealistic external and internal church functioning expectations created a perfect storm of emotional, psychological, relational, spiritual, and behavioral turmoil. The participants came to their senses, and with self-determination and peer and family support, they became victorious over their mental health trials.

CHAPTER FIVE: CONCLUSION

Overview

This study shed light on the experience of American church leaders who have experienced mental health episodes during their church leadership. The first section provides a summary of the findings, then a brief discussion of the results in conjunction with relevant and available research. The following section discusses what these findings implicate for Christian leaders. The final sections discuss the delimitations and limitations of this study and suggestions for future research.

Summary of Findings

The results of this study revealed several findings. Although the interpretations of these findings are limited and cannot be generalized to every Christian leader, the findings are significant and illuminate a real problem in today's Christian ministry. The research study identified five themes from participants' stories about their experience of mental illness during their tenure as church leaders. The five generated themes were: training and education did not prepare for the realities of church leadership, the problem of stigma in the church, difficulties coping with the overwhelming stress, the source of mental illness, and the transition into healing and restoration. The purpose of the themes was to describe the participants' lived experiences with mental illness within their ministry role. The themes derived subthemes from further insights into each participant's understanding of church conflicts, emotional and psychological problems, excessive work, and unrealistic expectations.

The researcher's process of listening to each participant's story of their experience with a severe mental health episode in conjunction with their work in their local churches revealed common threads of discontent with church leadership. Pastors go into ministry with the hope of being successful servants of God and God's people. Pastors obtain the skills, knowledge, and training propagated in today's society through seminary and/or college. However, becoming a church leader

does not fully prepare a person for the interpersonal challenges of ministry, nor is the topic of mental health sufficiently explored, studied, or integrated into the lessons in church leadership.

Research Question One

What are the lived experiences of church leaders with mental illness?

All the participants experienced the culmination of stress and subsequent de-escalation into a severe mental health episode. There is only so much pressure an average person can take before they break mentally, emotionally, spiritually, and physically. Ten participants talked about working grueling schedules, equating to being on-call 24 hours per day, 7 days per week. The combination of crazy schedules, juggling other jobs, family, and church functioning eventually caused them to fall victim to emotional instability. Six pastors thought of suicide; all the participants experienced feeling overwhelmed, hopeless, helpless, and depressed. All the participants spoke of the stigma in the church and fear of losing their job as reasons they delayed seeking help. Paul had become so disappointed and overwhelmed with pain from internal and external stressors, and if he had not gotten the help he needed right then, he stated, “If I had not gotten the help when I did, I would have hit a breaking point.”

Research Question Two

What were church leaders’ experiences with help-seeking during their mental health episodes?

Participants discussed that their motivations for seeking help were predicated on a shift from negative to more positive thinking and the support of family, peers, professional doctors, and therapists. Of the participants, 45% were unashamed and unafraid of judgment to see a medical doctor, psychiatrist, or therapist. One participant, Jonah, thought he was losing his mind, prompting him to think, “I’m gonna go check myself into a psychiatric hospital,” but he ended up seeing a psychiatrist instead. The rest of the participants split evenly; 27% handled their problem without outside assistance; several had help from other pastors, family members, or professionals. Realizing that their situation was not just about lack of willpower or self-control and that it was not a sign of

"weakness," but an actual mental health emergency, were the critical factors that led the majority to seek help from professional resources. Paul expressed how divisions in the church had made him think about quitting, and this precipitated his help-seeking:

> All I was doing was trying to put out fires, and I wasn't doing that very successfully, and so [being a pastor, something] I'd been doing . . . since I was 19 years old, for the first time in my life, I was receiving no joy from it, and that's when things got kind of scary for me, and I realized something was wrong enough for me to talk to one of my good friends . . . and my personal physical doctor.

A change in mindset was a needed action for all the participants to overcome the devastating emotional trial.

Research Question Three

How were church leaders' relationships during the mental health episode?

Participants discussed how various relationships contributed to or helped them deal with their psychiatric episodes. Four participants had to deal with being betrayed by members of the church.

Wives, husbands, family, fellow church leaders, and close friends were integral to the participants' recovery. For those pastors who were married, their spouses knew them best and noticed that the pastors were not themselves and helped encourage them to seek assistance. One participant, Rachel, could not hide her emotional issues with her family, "They knew everything, and were great." Another participant, Paul, confirmed the importance of a supportive family, "My wife was the one who saw it most. My kids, they saw it, but they just didn't know what to call it." Isaac saw the importance of trustworthy friends with whom one can laugh and have good times:

> Hanging out with friends . . . having fun together . . . I'm not sure that I'm good at making those times happen during low times, but I think [these friendly relationships] bring me out of [depression episodes] or maybe even keep me from [decompensating mentally].

The pastor-spouse, pastor-family, pastor-pastor, pastor-mental health professional, and pastor-friend relationships and trustworthiness were deciding factors in overcoming and maintaining stable mental health.

Discussion

This IPA study explored the lived experience of 11 Christian pastors in the Dallas, Fort Worth area. The researcher used an interpretive method to identify five superordinate themes and 15 subthemes. In this discussion, the researcher arranged the literature review into two sections. The first section included the theoretical framework of Heidegger's interpretative phenomenological philosophy. The second section was an overview of related literature about theories of help-seeking behavior, factors of mental illness, and the issues facing Christian pastors. The IPA theory and theoretical and empirical literature led to the development of the identified themes of training and education did not prepare for the realities of church leadership, the problem of stigma in the church, difficulties with the overwhelming stress, the source of the mental illness, and the transition into healing and restoration. These five themes helped connect the literature review and the theories that framed this study.

Empirical Literature

The participants' experiences of mental illness aligned with the results of other studies about psychiatric issues and the church culture of stress, burnout, conflicts, and the influence these issues have on the mental functioning of pastors. Surprisingly, only 3 of the 11 participants identified the devil's influence and spiritual nature as part of their mental health episodes. Joseph discussed how when people rebel against God, they open themselves to being bound by the enemy. Joseph stated, "I think [being reprobate] begins the slow process of the devil taking a foothold in our lives so that the error of our ways becomes greater to the point where a significant may issue arise." This study's findings corroborate the evolution of Christian theology to demystify God, which increased in the 20th century because of the advancements in science and increases in secularism and humanism

(Goldberg, 2008; Silver, 2006). In one study of 39 Lutheran pastors' belief in the paranormal, 95% of the pastors believed in the spiritual world; however, six of the participants conceded supernatural phenomena could be natural expressions that are "psychological, biochemical, pharmacological, or physical" (Ruehs, 2022, p. 76). The non-belief in the supernatural is curious because there are over 100 Bible verses about demons, the devil, and evil spirits. C.S. Lewis (2002) stated, "There are two equal and opposite errors into which our race can fall about devils; one is to disbelieve in their existence" (p. 125). During a conference in Texas in 1971, Billy Graham said he believed some demons negatively impacted a person's inner functioning as described in the Bible. Billy Graham also thought there were still demons doing the same thing in modern times and are involved in many psychiatric cases (Graham, 2016). The man in the tombs in Mark chapter five, whom the scripture says was possessed by literal demons, would be placed in a psychiatric ward today and be diagnosed with schizophrenia.

Another issue is that several of the participants struggled with defining mental illness. Difficulties defining mental illness are not a new phenomenon, as research has been ongoing to address the issue of poor mental health literacy (Jorm et al., 1997). Jorm et al. (1997) defined mental health literacy as "the knowledge and beliefs about mental disorders which aid their recognition, management, or prevention." Delays in treatment and recovery will continue until communities improve their knowledge and understanding of mental health (Jorm et al., 1997).

The experience of these participants, where stigma in the church was a problem, aligns with what other researchers have found when studying church culture around mental health. Eighty-seven Catholic clerics in Aramouny et al.'s (2020) study agreed with several shameful statements in the Community Attitudes Towards Mental Illness questionnaire. The statements such as "91.9 %" agreed powerfully with the statement "The mentally ill do not deserve our sympathy," "85.1%" strongly agreed that "The mentally ill are a burden on society," and "87.3%" supported "It is best to avoid anyone who has mental problems." According to Aramouny et al. (2020), "Clerics viewed the

mentally ill person as someone who is inferior and requires supervision and had a rejection of mental health services in the community" (p. 264). Religious stigmatizing attitudes toward mental illness are not held only in the United States. Of Arabic-speaking spiritual leaders in the sample for Krstanoska-Blazesk et al.'s (2021) study about this issue, 43.1% endorsed the belief that people with psychiatric problems are "weak." (p. 7).

This research study confirmed the results of other studies of pastors that our church leaders are highly stressed and deal with mental problems. Whitson's (2014) analysis of 36 pastors and the factors contributing to their resignations showed that the entire sample experienced some significant adverse life-impacting events. It is questionable why nothing has appeared to change much as pastors continue to struggle tremendously despite the continued research into this area. Proeschold-Bell and Byassee (2018) fought to bring the many problems faced by church leaders to the forefront in their book, *Faithful and fractured: Responding to the clergy health crisis*. Proeschold-Bell and Byassee provided a thorough breakdown of the available research statistics that have not changed, and pastors remain highly stressed leading to far-reaching debilitating consequences. Proeschold-Bell and Byassee summed up this issue in one sentence, "Ministry is complex" (p. 28). The participants in this study attested to this principle, unable to understand the preventive solutions that contributed to their mental health crisis.

This study's results highlighted that there is a lack of helpful knowledge about mental health assessed within many churches. Only three participants in this study confidentially answered the question about the definition of mental illness. Paul had fewer delays answering this question:

> I'm sure that there's a clinical definition, but for me, as a believer, mental illness would be that when you know that your soul is not as it should be, and that can take on a lot of different manifestations physically, emotionally, spiritually, [and] mentally I think that it plays out in a lot of different ways..... I would simply define it as your soul not being as it should be.

The remaining eight participants visibly and verbally struggled to answer this question voicing several ums and uhs, false starts, long pauses, and statements like:

> I think mental illness is kinda the broader term for um, of-of a variety of different, uuh, I guess conditions that-that we see or talk about today, uuh, and it's-it's become more (long pause) I-I'd [don't] know if [this] is the right word, but more talked about, um, well, I guess I'm trying to say, but anxiety, um, depression, um and-and I would-I don't [know] if this is right or not, but I would, uh, say, ya know, to-to the far-furthest extremes, uuum, uhh, ya know, in to uhh conditions like schizophrenia, and uum associate-dissociative personality disorder.

Also, there is disbelief in the supernatural. One participant believed in a need for the reinterpretation of the Bible for the verses about spiritual beings. Only 27% of these participants discussed the spiritual influence on the mind, behavior, and emotions. Rachel did not believe in the separation of mental health issues into different spheres:

> Your well-being has a lot to do not only with what is going on physically . . . but also chemically, what's going on in your brain, what you're choosing and how you're choosing to think about things, plus your experience of trauma. . . . All these things go on in your soul. . . . They all overlay each other.

Another is the extent the church culture of stigma, unrealistic expectations, and critical judgment plays a part in the pastor's death by suicide. When pastors are suicidal, they do not think they have any other option because they do not know an available program, have dedicated support, or struggle with pride, fear of rejection, loss of career, or punishment. Five participants discussed how the barriers of shame, guilt, and unsupportive church members prevent suicidal pastors from getting the help they need. When it comes to suicidal pastors, Rachel's response was, "There are church leaders who get it and care; you've got to find those people, [but] I know [some] churches that deny the reality of mental health problems." Elizabeth believed that suicidal pastors should look for help

outside their church if they do not feel supported and conflicts occur. Isaac took a long time to answer:

> That's a great question ..... It seems trite to just say, "gather good people around you." I think mental health has become something that is more talked about now, and I think that this is the right move. I still think in churches we're behind on talking about it. Then, sometimes when you're a pastor, it's taboo to have real human issues.

Daniel was another who was troubled by this matter:

> That's a difficult question ..... When one is to that point [being actively suicidal because of too many problems] ..... there is no getting help. That's the scary part. I don't think that anyone knows. I'd be open if somebody had a great answer, but I don't know if there is anything you can do for someone who's already there [actively suicidal] ..... Nobody knew that about me. Nobody knew that I was thinking about blowing my brains out or [dying by] carbon monoxide poisoning.

Hezekiah expressed his frustration:

> The problem with giving you that answer [what should pastors do when they feel suicidal] is I feel like so many pastors don't have safe people in their corner..... They've got the wealthy CEO on the church board because he's a big tither, and the dude's as unhealthy as the pastor. . . . I just don't think so many guys don't know whom to call.

Theoretical Literature

Three theories guided this study to gain an interpretive view of the pastor's mental health illness while engaging in church work. A combination of Heidegger's phenomenological philosophy, the TPB, and the theory of CDHS were the principal foundations for this study. Those who employ phenomenological philosophy want to understand a person's inner beliefs within interdependent relationships (Smith et al., 2009). The participants of this study willingly shared their experiences to reveal emotions, thoughts, behaviors, and outcomes of their experience with a mental health episode.

The TPB encompasses that a person's actions are predicated on three factors: a person's judgment of a particular behavior, how social factors influence their behavior, and the person's belief in their ability to handle the behavior without any outside interference (Ajzen, 2005, p. 118). The CDHS established that a person's motivation to look for assistance is centered on the cultural beliefs of a person (Arnault, 2009). The participant's church culture significantly contributed to the escalation of stress and subsequent mental disorder and influenced the participants' help-seeking behaviors. The pastor role is a unique experience; when a person chooses the ministry, they decide to enter another world and take on its qualities and characteristics. Although each participant went through either seminary or attended a university, what they gained helped with smooth and stable integration into the faithful ministry.

The participants' concerns and experience with stigma occurred within the church system, and the participants saw themselves as different from other church members. Still, the pastors and their congregants were dependent on one another. Social pressure influenced the participants' self-care behavior. All the participants experienced emotional and mental breakdowns during their ministry job and within their church, family, and friend relationships. The participants' beliefs about the source of mental illness and their social support contributed to their actions in getting help when they could no longer hide the fact they were struggling. The five themes identified in this study were: training and education did not prepare for the realities of church leadership; stigma in the church; difficulties coping with overwhelming stress; the source of mental illness; and the transition into healing and restoration. These themes help describe how a pastor just starting in the ministry goes through a kind of crucible of interpersonal conflicts and must come face-to-face with the reality that they are human.

Implications

This qualitative study illuminated theoretical, empirical, and practical implications. The results of this study could help contribute to the development of appropriate intervention and continued study into Protestant and non-Catholic churches. The Christian pastors in this study

revealed the importance of better training and education. Also, there is a need for increased advocacy in church congregations and the development of targeted programs for those who have experienced severe mental health episodes during their tenure as church leaders.

Theoretical Implications

This research advanced Heidegger's phenomenological theory, the TPB, and the CDHS theory. This researcher explored the collaboration between the lived experience of the pastors within the confines of the Christian lifestyle. When it came to seeking help, the pastors' behavior was predicated on their outlooks toward mental illness, which was influenced by stigma. Other factors that influenced help-seeking included the social pressure to present as a stable leader despite how they were feeling and how the participants believed they could handle the psychiatric problem on their own, and the church culture played a significant role in the participants' development and subsequent recovery from the dysfunctional mental health episodes.

Empirical Implications

This study advances the investigation of the influences, challenges, and barriers to preventive measures for Church leaders struggling with mental illness. The lack of preparedness, the overwhelming workload, the unrealistic expectations, the development of severe emotional and often suicidal ideation, the helpfulness of social and professional support, and a change in perspective were factors mentioned by all participants. The study's participant experiences supported the notion that better training, education, and preparation are needed—more advocacy for changes in church culture toward mental illness—and the need to develop pastor-specific mental health programs.

Practical Implications

The seminaries and colleges need to update and expand their curriculum to include training and education in mental health. For this study, one participant had only one class on mental issues; another could not recall receiving any training in behavioral and cognitive topics. In 1995, Weaver looked to answer whether the training of church leaders in mental health topics was adequate. Weaver

completed a systematic review of studies published between 1976 to 1989 about American and Canadian Christian and Jewish leaders. Weaver concluded that there was a dire need for improvements in pastoral training and education in mental health. Thirty-eight years later, Ross and Stanford (2014) published similar results from their survey of 70 directors of accredited theological schools. Ross and Stanford identified four problems with church leader development programs (p. 184): (a) mental illness is not integrated as a critical and vital area of intentional study; in this study, two participants mentioned the little attention given to mental health topics, (b) programs' unwillingness to declare what they believe and support mental health problems; the participants in this study discussed how stigma continues to be a problem, (c) there were no efforts to take the lessons from the classroom to make them more interactive and explorative into the vast and complicated world of psychiatric and religious phenomena; the students training to become therapists must gain hands-on knowledge of interacting with clients through internships; training in mental health is not a priority for church leadership training and education; the participants in this study expressed the challenge of needing more preparation to deal with interpersonal issues, (d) there needs to be more active efforts to address the issue of lack of training and education in mental health. After decades of research and advocacy for acceptance of mental illness topics, Christian training programs are prevalently addressing the problem; unfortunately, nothing seems to have changed. It is impossible to generalize the results of Letizia's (2022) qualitative survey of 13 Protestant education programs. Still, the results of Letizia's study align with other research findings about Christian leadership training, such as Salwen et al.'s (2017) study of 251 seminary students, in acknowledging a continued lack of mental health courses. Ministers should seek to become more knowledgeable about mental health and not divorce this issue from the spiritual aspect. Still, the programs that are supposed to prepare them for their role must adequately prepare them for mental illness. The Bible says that men perish for lack of knowledge, and pastors succumb to the pressures of church ministry, not understanding the path to healing and prevention.

Church congregations must also be educated and helped to overcome critical and judgmental views about people or their pastors who struggle with mental health. The Bible describes how the church of Christ is supposed to operate and support one another without any hypocritical judgment, and church leaders especially are to be supported (1 Peter 2:17; Philippians 2:3; Galatians 6:6-9). 1 Thessalonians 5:12-13 admonishes congregations to respect their leaders, not judge them for not being perfect. Several participants in this study talked about not feeling safe to disclose their problem with mental illness to their church because of unresolved stigma. Although research studies show that more churches support mental health, current results of religious participants indicate ongoing negative views of mental illness within Christian congregations (Peteet, 2019; Stanford, 2007).

Beginning pastors should have complete clinical and psychological evaluations before starting a ministry. The cognitive and behavioral health career is a complex path to engage. Lent (2013), one of the founders of social cognitive career theory, understood that choosing a career is based on several factors, including personal characteristics, ability to gain and apply knowledge, social and emotional intelligence, and varying challenging life experiences (p. 115). Lent (2013) believed career assessments help people choose roles that fit their knowledge and abilities. Counseling psychology professor Dr. Joseph Hammer broke down 21 types of psychiatric jobs. Hammer (2016) created the "Mental Health Professions Career Test" to clarify all the different aspects of being a mental health professional. Hammer identified "181 work tasks" employed by mental health professionals. Pastors are inadvertently expected to know how to perform these 181 responsibilities and church duties without any knowledge or training. It is unknown if pastors were given career assessments before taking on their leadership roles.

Christians can argue against the use of secular assessments given that many would-be pastors feel called by God. However, a counter debate can point to stories in the Bible where godly protagonists went through pagan training and valuation, all under the assumed plan of God. The book of Daniel relates the trials of the Hebrews Daniel, Hananiah, Mishael, and Azariah while in God-

ordained Babylonian captivity. These Hebrew boys needed to possess the ability to learn and serve in King Nebuchadnezzar's kingdom. Eventually, the boys' knowledge of the Babylonian training program was tested. God supplied the knowledge, wisdom, and understanding, and the boys had to apply these abilities in their work for the king.

Delimitations and Limitations

This researcher decided to limit participants to the non-Catholic faith because of a plethora of studies of the Catholic faith spanning several decades but a lack of non-Catholic research. This researcher decided to limit the boundary to one city rather than state or nationwide due to the plan to gather a small sample size. The title of church leader can include other roles (e.g., deacon, bishop, chief officer). Still, the criteria were limited to titles of pastor or minister as the focus was on those with the highest authority over their congregations and expected that their influence is more significant than lesser roles. This research did not involve grounded theory because this researcher was not looking to "develop a more subjective understanding of" this topic (Marek, 2015, para 3.). Ethnography was inappropriate, as this researcher was not looking to go into the field to observe the pastor's lifestyles within a social context (Austin & Sutton, 2014; Moustakas, 1994). Last, the researcher used hermeneutics philosophy as a therapeutic framework, not the methodology. At first, the researcher considered using the hermeneutical methodological approach in this study. However, after further investigation, the researcher surmised that the hermeneutical process needed to be simplified and more time-consuming. IPA was the chosen analysis method because this researcher's conceptions were a vital part of the interpretative process (Smith & Osborn, 2008).

Recommendations for Future Research

The results of this study have several implications for future research in the following areas.

First, research is needed to investigate pastors' training and education programs. One of the participants in this study stated they had just one course in mental health; other participants could not recall any training in mental health topics. All the participants expressed the surprise and

disappointment of being unprepared for the interpersonal challenges they faced in their work. According to Zippia.com's (2022) recent statistics on American pastor demographics, there are more than 31,352 active church leaders. This researcher could not apply the results of this small qualitative study to the general public. Quantitative studies would be appropriate given that thousands of colleges and seminaries train and educate church leaders and thousands of pastors; quantitative research would allow for the generalization of the data revealed in studies (Bhandari, 2022). Novice and expert researchers from around the United States need to be willing to look into the training and education issues within the different Christian denominations.

Second is the development of faith-based interventions specific to church leaders. Although there are programs for church leaders, they seem limited to particular local denominations and not more universal. One participant in this study, Joseph, discussed the difficulties struggling pastors have when feeling overwhelmed and not knowing whom they can go to for help. There are programs, but pastors are not accessing them. Marble Retreat (n.d.) is an eight-day program created in 1974 for Christian leaders regardless of denomination. The retreat's founders, Louis McBurney, and his wife, saw the need to help Christian leaders deal with overwhelming problems leading to psychiatric issues. The McBurneys (n.d.) were concerned about pastors' mental health, blaming the fact that pastors overcome by stress do not know what to do, "They find it difficult to seek help" (para. 1). Forty-eight years after Marble Retreat's founding, not much has changed. Pastors are still struggling and not finding the assistance they need. Scott Free Clinic is working hard in the trenches to address "a record need and demand for pastor care" (Scott, 2021, para. 3). A Google search for "pastor support" resulted in several resources. Still, why troubled pastors are not accessing these resources needs to be researched. This researcher suggests the quantitative methodology to reach a more significant number of participants to gain more insight into the dilemma of pastors not accessing available interventions.

Third, how individual churches help their pastors must be investigated. Research is needed to help develop a pastoral psychological and spiritual assessment because some participants mentioned having preexisting problems with depression. Before taking on a highly stressful ministry job, pre-testing could identify issues and better prepare people to enter church ministry. Hall (2017) confirmed the inadequacy of ministry education, stating, "academic training does not prepare someone for ministry" (p. 42). Cadge et al. (2020) found similar results in their qualitative study of 21 chaplaincy training programs. Cadge et al. (2020) reported a lack of clarity between program curricula and the difficulties of preparing church leaders for ministry.

Fourth, a focus group should be considered to explore the unexpected results of this study—the non-id of the spiritual nature of mental illness. According to Edmunds (1999), focus groups are a helpful way to obtain a more subjective perspective from participants about a specific topic. Watkins and Neighbors (2007) used focus groups comprised of 46 Black male college students to explore the participants' beliefs about mental health. The participants in Watkins and Neighbors' (2007) study revealed concerns about stigma and not being understood by providers prompting the need for more culturally influenced adjustments to interventions. The Bible is full of supernatural language and precepts. It would be interesting to dive deeply into why some pastors do not believe in the spiritual world and how this impacts their ministry. A focus group could focus on the different denominations to compare beliefs about supernatural influences in our culture. Another use of a focus group would be to explore the "us versus them," how leaders differ from parishioners. The expectations a person places on themselves drive their behaviors, and pastors have succumbed to overwhelming stress because they believe they must handle everything in their ministry.

Fifth, wives and their families are at the front lines of the battles in their pastor spouses' lives. Luedtke and Sneed (2018) acknowledged that researchers neglect pastors' families; this prompted these researchers to engage in a qualitative study to explore the lives of nine clergy wives. The nine participants in Luedtke and Sneed's (2018) study revealed feeling stressed from the external pressures

to demonstrate preconceived ideas of how a pastor's wife should be, pervasive feelings of aloneness in their struggles, giving of themselves above average, and financial difficulties. In another study of pastor wives of churches in China, Chan and Wong (2018) helped 15 wives expose their pain and suffering. Despite different cultures, the experiences within the Christian church are similar. Chan and Wong's (2018) participants expressed the same sentiments as Luedtke and Sneed's (2018) participants, citing economic difficulties and feeling like they had no help. The wives' church experience in Luedtke and Sneed's and Chan and Wong's (2018) studies is similar to the participants' knowledge in this study. Brian and Cara Croft's book, *The Pastor's family: Shepherding your family through challenges of pastoral ministry,* extrapolates on the issues experienced by the pastors' family members. Pastors' families too often are neglected for the needs of others. The public celebrates pastors as "great and faithful laborers for the sake of Christ, but whose marriages and families were sacrificed-for noble reasons on the altar of their ministry" (Croft & Croft, 2013, p. 23). Cara shared her battle with emotional issues and her fear that Brian would be critical of her struggles (Croft & Croft, 2013) .

Abraham was the only divorced participant in this study, and he cited the cause as his ex-wife's lack of support through his many trials. Abraham did not blame ministry work as the primary catalyst for his mental breakdown. Abraham stated, "My ministry wasn't stressing me at all; I was in a very stressful marriage that was stressing me to the point of breaking ..... [My ex-wife] was dismissing me even though she knew the medications I was on." Solomon shared that he and his wife were going to marital counseling to address communication, perspective, and role differences. Solomon stated:

> My marriage is well; we go to counseling together not because something's wrong [but] we wanted to work through . . . we're not talking the same language ..... because I have a full-time job, and she stays at home; we have vastly different realities. She spends all her time thinking about our children. I do not.

Paul also mentioned some family issues stating that “every seven years,” he has his wife “jump on the crazy cycle” because they “handle things differently.” Five participants in this study identified family conflicts as a major issue during their mental health episodes. Additional qualitative and quantitative studies focused on Christian families are needed.

Sixth, outpatient mental health programs need to develop programs specifically for church leaders. Pastors are in a class of their own with unique challenges. Several participants in this study mentioned the “us versus them” concept viewing themselves as different than their staff and congregations. Rachel discussed how being elevated to higher leadership alienated her from regular church members. Rachel stated, “The further I get in church leadership, the less friends I seem to have at my church..... I need to always filter because there’s so much that I know behind the scenes that I can’t share and be honest with my friends at the church.” Rachel was disappointed that her connection to the lead pastor negatively impacted her relationship with others in her church. Rachel’s lead pastor had conflicting issues, leading Rachel to believe church members would no longer talk to her because of her role in the church.

Costello et al. (2020) sought to address the need for faith-based interventions by testing the Mental Health First Aid program on 27 participants who were either regular church members or church leaders. Mental Health First Aid is a complete system of mental health education and instructions in appropriate support and intervention. The results of Costello et al.’s (2020) study indicated that with education and training, church members gained more knowledge and were more confident in helping those with mental illness. There was a decrease in stigmatizing beliefs. Costello et al. (2020) acknowledged the need for a more in-depth and larger sample size to test the efficacy of MHFA, and more research on faith-based interventions is needed.

Reflective Research Journey

Reflections On the Beginning Process

As a believer, issues in the church are critical to me, but the choice to dive deeply into the troubling topic of pastor mental health was not something I initially had decided to research. I started out wanting to investigate sexual abuse in the church, and for the first three years, I focused my efforts on this. I gathered the literature and created preliminary chapter write-ups, but something made me abandon all the work I had done on this topic. It was December 2019; I was busy juggling school, work, and my part-time counseling services. I was providing therapy for a pastor struggling with conflicts in his local church. He did not feel supported, wanted to quit, felt no one cared about him, and was seriously hopeless. At the same time, news articles about pastor suicides kept appearing on Google searches. I gained conviction, and I believe the Holy Spirit spoke to me, not literally but in my spirit, saying this was the topic I needed to explore, pastors with mental illness, and what is keeping these leaders from getting help before it is too late.

I took the initiative to get more training on the IPA method and was grateful for the coaching and guidance I received from an IPA-specific education program. Being a Christian for 13 years and a licensed clinical social worker for 17 years, I realized I would need to bracket my preconceived religious and clinical knowledge and experiences not to interject any bias into the project (Chan et al., 2013). Feeling confident I was on the right path, I forged ahead vigorously, gathered the literature, and settled on the IPA method. A literature review only confirmed what I knew from my work and education. What became clear was that although the research clearly showed how much pastors were suffering and the adverse outcomes of resignation, burnout, immoral behaviors, and death, what was not clear was what processes were going on before the critical results. Getting IRB approval was frustrating because of my research naivety; I had to submit multiple modifications before obtaining permission to proceed with the research.

I thought it would be essential to talk with a pastor to get guidance about approaching church leaders for the study. I was excited when a pastor from a friend's church agreed to speak with me, but that excitement turned to disappointment as this pastor told me that no minister would want to talk to me about this sensitive topic. At first, I was resigned to accepting this pastor's negative outlook because I was already anticipating it would be difficult to get participants because of the nature of the topic and the common knowledge about church secrecy. I pushed on, believing that since God gave me this assignment, He would provide the willing participants, and He did so beyond my expectations! I was nervous about how I would gather the information I needed to answer my research questions. One of the first things to happen after this was another pastor agreeing to participate in a pilot interview. The pilot interview was a tremendous help in revising some of the research questions to align with the IPA method, which calls for questions not to be manipulative or leading.

Reflections On the Data Collection Process

I was ready to accept that it would take many months to find pastors willing to share their stories. I was still determining what kind of response I would get from advertising my flyer on social media and felt more confident in the email method. I was happy that the money spent to purchase the email list of local pastors helped produce the majority of willing participants. I was also shocked by how quickly I obtained ministers who agreed to the interview. The fact that I got so many participants was a blessing and a curse. I planned to give the participants a gift card and pay a company to transcribe the interviews. I thought I would have plenty of time to afford this because it would be many months between getting willing participants, but I was wrong. My miscalculation caused me to delay rewarding the gift card, and I had to transcribe the rest of the interviews myself, which was very time-consuming and frustrating. I was grateful for the participants' patience with receiving their reward past the promised due date. I thought it was appropriate to complete the interview via Zoom,

and the participants appreciated the convenience of the setting that helped facilitate a safe and open discussion.

During the interviews, I was moved by the pastors' stories. I had to maintain a robust internal boundary and fight desires to go into counseling mode and ask more questions than could be used for the study. I felt sad, angry, and empathetic as the participants' stories brought the suffering of God's leaders to reality. During each interview, I wanted to reach out and provide comfort and supportive dialogue, striding the line between counselor and researcher but going back over the IPA principles helped keep me from crossing the line. One issue that stunned me was that only a few participants mentioned the spiritual nature of mental illness. A probing question like, "Is there any other reason you think could tribute to mental illness?" produced the answer "no." This answer was questionable, given that over 80 Biblical verses mention spirits or angelic beings, and one specific verse, Ephesians 6:12, says that there is another world not seen by human eyes, where authentic entities operate with wicked agendas towards humanity.

Reflections On the Data Analysis Process

I thought this stage in the dissertation would be the hardest, and admittedly, I procrastinated the most in this section which is typical for researchers new to the IPA method. As Smith et al. (2009) stated, it is a "daunting" task (p. 81). I obsessively followed the steps provided by Smith et al. to help lessen the overwhelming and insecure feelings I struggled with initially. Smith et al. recommended novice researchers do things manually by printing out a hard copy of the transcript to do the exploratory writing for analysis. Using the printed transcripts was much easier to follow the IPA steps for research. The process of reading, rereading, classifying meaningful words and comments, and creating experiential statements to use in writing up emergent themes for 11 transcripts was a time-consuming, depressing process. I knew it would take some time to analyze interviews, but it took almost a year to complete the analysis after transcribing them. After feedback from my chair, I used the computer and online program MAXQDA to reanalyze the data.

Part of the delay was that I would get a little depressed and disheartened after finishing the transcript analysis. Going back over the transcription and the recorded interviews and hearing their stories was like opening a sutured wound repeatedly. I felt so much relief once I finished the last transcript.

One curious phenomenon occurred during nearly every interview. As I went through line by line, a pattern emerged as participants chuckled or laughed during parts of the conversation. I thought this behavior was odd, given that the talks were about severe mental issues, including suicide. I wondered if this was an unconscious defense mechanism of humor to cope with nervousness because of the nature of the topic (Di Giuseppe & Perry, 2021). For example, when Elizabeth answered her thoughts about church leaders stressed with emotional issues, she stated, "If you give everything you have to the church, to the ministry, you will not have." She chuckled, then said, "a healthy life physically or mentally or a healthy marriage or a healthy family." Another participant, Joseph, chuckled when talking about a time he thought he had a heart attack. Hezekiah had a similar response when discussing his thoughts about pastor suicides:

> Yes, I believe [pastor suicide] is true cause my phone rings at least once a week from a peer in the ministry. . . . I'm a nobody, yet my phone is ringing off the hook. . . . I've committed . . . I'm gonna spend the rest of my life trying to keep pastors having conversations, [he chuckles], towards their soul health . . . so I keep answering the phone.

Reflections On the Final Process

This exploration of the lives of a few pastors has been a heartfelt and challenging ordeal, but I am thankful to God and the participants for their willingness to open up about a painful part of their past. I felt the pressure lessen as I identified and organized the themes. I felt great accomplishment when I finished the evaluation process for all the transcriptions and created the main group themes and subthemes. I was happy that writing the results was easier than I thought it would be. I felt satisfied with the participants' confidence in my presentation of their experience. This experience has

helped drive me to want to bring more focus on the need for more help for our pastors who continue to struggle with overwhelming problems.

Summary

This phenomenological study gained insight into the experience of Christian church leaders who developed mental health problems while working in their local churches. The implications identified in this study are the need for improved education and training for aspiring pastors, the development of pastor-specific interventions, and increased advocacy within churches to overcome the stigma of mental illness. The willingness of the participants to share their stories provided an understanding of the phenomenon.

Pastors continue to struggle despite decades of research, hundreds of books, and published recommended solutions for the proper ways to help today's church leaders in their ministry work. Why our pastors continue to fall victim to the many dysfunctional, unrealistic, and unprepared for the realities of doing the self-sacrificing role of a pastor is unclear. More research is needed to explore how pastors consider their role in today's social challenges. According to 2 Timothy Chapter 3:1-13, people struggle with negative behaviors making it challenging to develop and maintain healthy interpersonal relationships. Interpersonal situations influence a pastor's mental struggles.

The pastoral mental health experience includes not being adequately prepared for the leadership role, the problem of stigma still within many churches, the overwhelming stress and unrealistic expectations placed on pastors, the development of psychiatric symptoms, and the eventual recovery with a change in perspective, professional, peer, and family support.

The results of this study align with other research that confirms the troubles Christian leaders are dealing with today. Still, the information is not helping prevent pastors from resigning, giving in to immoral behaviors, and, most devastatingly, suicide. More concentrated efforts need to be engaged to educate congregations, better equip pastors, and make the availability of resources more transparent to prevent and better manage ministry challenges.

REFERENCES

AbuRuz, M. E. (2019). Patients with segment elevation myocardial infarction: Moderating effect of perceived control on the relationship between depression and in-hospital complications. *BMC Cardiovascular Disorders, 19*(143), 1-7. https://doi.org/10.1186/s12872-019-1126-z

Ackerman, C. E. (2020, July 17). Cognitive distortions: When your brain lies to you (+PDF worksheets). *Positive Psychology*. https://positivepsychology.com/cognitive-distortions/

Adams, C. J., Hough, H., Proeschold-Bell, R. J., Yao, J., & Kolkin, M. (2017). Clergy burnout: A comparison study with other helping professions. *Pastoral Psychology, 66,* 147-175. https://doi.org/10.1007/s11089-016-0722-4

Ahonen, L. (2019). *Violence and mental illness: An overview*. Springer.

Ajzen, I. (2005). *Attitudes, personality, and behavior*. Open University Press.

Akers, T. (2020, February 25). Pastor Jarrid Wilson supported me hours before he died. Don't forget: Ministers need ministry too. *Newsweek*. https://www.newsweek.com/pastor-jarrid-wilson-supported-me-hours-before-he-died-dont-forget-ministers-need-ministry-too-1488845

Alase, A. (2017). The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *International Journal of Education & Literacy Studies, 5*(2), 9-19. http://dx.doi.org/10.7575/aiac.ijels.v.5n.2p.9

Alund, N. N. (2019, September 11). Former Nashville pastor Jarrid Wilson dies by apparent suicide, wife reports. *Tennessean*. https://www.tennessean.com/story/news/2019/09/11 /jarrid-wilson-died-suicide-former-nashville-pastor-dies-wife-says/2284214001/

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.

American Psychiatric Association. (2019). *Stress in America 2019*. https://www.apa.org/news/press/releases/stress/2019/stress-america-2019.pdf

An, C. H., West, A. D., Sandage, S. J., & Bell, C. A. (2019). Relational spirituality, mature alterity, and spiritual service among ministry leaders: An empirical study. *Pastoral Psychology, 68,* 127-143. https://doi.org/10.1007/s11089-018-0846-9

Andrade, L. H., Alonso, J., Mneimneh, Z., Wells, J. E., Al-Hamzawi, A., Gorges, G., Bromet, E., Bruffaerts, R., de Girolamo, G., de Graaf, R., Florescu, S., Gureje, O., Hinkov, H. R., Hu, C., Yuan, Y., Hwang, I., Jin, R., Karam, E. G., Kovess-Masfety, V., . . . Xavier, M. (2014). Barriers to mental health treatment: Results from the WHO world health (WMH) surveys. *Psychological Medicine, 44*(6), 1303-1317. https://doi.org/10.1017/S0033291713001943

Aramouny, C., Kerbage, H., Richa, N., Rouhana, P., & Richa, S. (2020). Knowledge, attitudes and beliefs of Catholic clerics regarding mental health in Lebanon. *Journal of Religion and Health, 59*, 257-276. https://doi.org/10.1007/s10943-019-00758-1

Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using Zoom videoconferencing for qualitative data collection: Perceptions and experiences of researchers and participants. *International Journal of Qualitative Methods, 18*, 1-8. https://doi.org/10.1177/1609406919874596

Armstrong, T. D. (2016). African American congregational care and counseling: Transcending universal and culturally-specific barriers. *Pastoral Care & Counseling, 70*(2), 118-122.

Arnault, D. S. (2009). Cultural determinants of help-seeking: A model for research and practice. *Research and Theory for Nursing Practice, 23*(4), 259-278. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2796597/

Arnobius. (1871). *The seven books of Arnobius against the heathen*. (Roberts, A., & Donaldson, J., Eds.). (Original work published ca. 30-600). http://www.ccel.org/ccel/schaff /anf06.html

Austin, Z., & Sutton, J. (2014). Qualitative research: Getting started. *Canadian Society of Hospital Pharmacists*, *67*(6), 436-440. https://www.ncbi.nlm.nih.gov /pmc/articles/PMC4275140/

Balkis, M., & Duru, E. (2019). The protective role of rational beliefs on the relationship between irrational beliefs, emotional states of stress, depression, and anxiety. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 37*, 96-112. https://doi.org/10.1007/s10942-018-0305-7

Banschick, M. (2015, May 18). Clergy as counselor. *Psychology Today*. https://www.psychologytoday.com/us/blog/the-intelligent-divorce/201505/clergy-counselor

BARNA. (2003, January 13). *New study identifies the strongest and weakest character traits of Christian leaders*. Barna Research Group. https://www.barna.com/research/new-study-identifies-the-strongest-and-weakest-character-traits-of-christian-leaders/

BARNA. (2017). *The state of pastors*. Barna Research Group. https://www.barna.com/pastors2017/

BARNA. (2018, October 23). *U.S. adults have few friends-and they're mostly alike.* Barna Research Group. https://www.barna.com/research/friends-loneliness/

BARNA. (2020a, April 15). *The mental & emotional health of pastors and their congregants amid COVID-19*. Barna Research Group. https://www.barna.com/research/mental-emotional-health-among-pastors/

BARNA. (2020b, May 2020). *Pastors are tired, overwhelmed, and lonely*. Barna Research Group. https://www.barna.com/research/covid-19-pastor-emotions/

BARNA. (2020c). *The state of the pastor*. https://shop.barna.com/products/the-state-of-pastors

BARNA. (2021). *38% of U.S. pastors have thought about quitting full-time ministry in the past year*. Barna Research Group. https://www.barna.com/research/pastors-well-being/

Baruth, M., Bopp, M., Webb, B. L., & Peterson, J. A. (2015). The role and influence of faith leaders on health-related issues and programs in their congregation. *Journal of Religion and Health, 54*, 1747-1759. https://doi.1007/s10943-014-9924-1

Beals, C. A. R. (2016). *The art of belonging: Clergy formation & wellness* [Unpublished dissertation]. Acadia Divinity College. https://baptist-atlantic.ca/wp-content/uploads/2016/11/BEALS-DMin-Thesis-2016.pdf

Becker-Weidman, E. G., Jacobs, R. H., Reinecke, M. A., Silva, S. G., & March, J. S. (2010). Social problem-solving among adolescents treated for depression. *Behaviour Research and Therapy, 48*, 11-118. https://doi.org/10.1016/j.brat.2009.08.006

Berry, A., Francis, L. J., Rolph, J., & Rolph, P. (2012). Ministry and stress: Listening to Anglican clergy in Wales. *Pastoral Psychology, 61*, 165-178.

Bertram, S., Kurland, M., Locke, R. G., & Yawn, B. P. (2001). The patient's perspective of irritable bowel. *Journal Family Practice, 50*(6), 521-525.

Berwick, D. M., Murphy, J. M., Goldman, P. A., Ware, J. E., Barsky, A. J., & Weinstein, M. C. (1991). Performance of a five-item mental health screening test. *Medical Care, 29*(2), 169-176. http://www.jstor.com/stable/3766262

Bevan, M. (2014). A method of phenomenological interviewing. *Qualitative Health Research, 24*(1), 136-144. https://www.ncbi.nlm.nih.gov/pubmed/24413767

Bever, L. (2014, July 16). A Texas minister set himself on fire and died to "inspire" justice. *Washington Post*. https://www.washingtonpost.com/news/morning-mix/wp/2014/07/16/79-year-old-retired-reverend-set-himself-on-fire-to-inspire-social-justice/

Bhandari, P. (2022, August 19). *What is quantitative research? Definition, uses, & methods.* Scribbr. https://www.scribbr.com/methodology/quantitative-research/

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research, 26*(13), 1-26. https://doi-org.ezproxy.liberty.edu/10.1177/1049732316654870

Blair, L. (2018, March 11). In the isolated world of pastors, churches mum on troubling clergy suicides. *The Christian Post*. https://www.christianpost.com/news/isolated-world-pastors-churches-mum-clergy-suicides.html

Blair, L. (2019a, February 21). The children's pastor, a decorated detective, commits suicide after child porn found on the church computer. *The Christian Post*. https://www.christianpost.com/news/childrens-pastor-decorated-detective-commits-suicide-after-child-porn-found-on-church-computer.html

Blair, L. (2019b, May 7). After 40 years, megachurch pastor slams Christianity and quits, deacon claims he had an affair. *The Christian Post*. https://www.christianpost.com/news/after-40-years-megachurch-pastor-slams-christianity-and-quits-deacon-claims-he-had-affair.html

Blair, L. (2019c, October 27). Former pastor Ryan Bell on why he abandoned his Christian faith: I gave it my best shot. *The Christian Post*. https://www.christianpost.com/news/former-pastor-ryan-bell-on-why-he-abandoned-his-christian-faith-i-gave-it-my-best-shot.html

Blair, L. (2019d, October 29). Church in "shock" after Florida pastor, father, and 2 facing rape allegations, kills himself. *The Christian Post*. https://www.christianpost.com/news /church-in-shock-after-florida-pastor-father-of-2-facing-rape-allegations-kills-himself.html

Blair, L. (2021, November 12). Beloved Houston pastor's suicide stuns family, friends. *The Christian Post.* https://www.christianpost.com/news/beloved-houston-pastors-suicide-stuns-family-friends.html

Bledsoe, T. S., & Setterlund, K. A. (2015). Thriving in ministry: Exploring the support systems and self-care practices of experienced pastors. *The Journal of Family and Community Ministries, 28*, 48-66.

Boisen, A. T. (1971). *The exploration of the inner world: A study of mental disorder and religious experience*. University of Pennsylvania Press

Bonelli, R. M., & Koenig, H. G. (2013). Mental disorders, religion, and spirituality 1990 to 2010: A systematic evidence-based review. *Journal of Religion and Health, 52*(2), 657-73. https://doi.org/10.1007/s10943-013-9691-4

Booth, A., Hannes, K., Harden, A., Noyes, J., Harris, J., & Tong, A. (2014). COREQ (consolidated criteria for reporting qualitative studies). In Moher, D., Altman, D. G., Schulz, K. F., Simera, I., & Wager, E. (Eds.), *Guidelines for reporting health research: A user's manual* (pp. 214-226). Wiley.

Borchard, T. J. (2018). *5 new theories on the cause of depression*. Psych Central. https://psychcentral.com/blog/5-new-theories-on-the-cause-of-depression/

Bornsheuer, J. N., Henriksen, R. C., & Irby, B. J. (2012). Psychological care provided by the church: Perceptions of Christian church members. *Counseling and Values, 57*(2), 199-213.

Bourne, J. (2019, February 21). *Families struggle for answers after youth pastor commits suicide during child porn investigation*. CBS 47. https://www.actionnewsjax.com/news/local/families-struggle-for-answers-after-youth-pastor-commits-suicide-during-child-porn-investigation/923934944/

Boyd, A. (2018, February 2). *What is the minimum age one must be to become a fully ordained priest?* Quora. https://qr.ae/pGHckq

Brakowski, J., Spinelli, S., Dorig, N., Bosch, O. G., Manoliu, A., Holtforth, M. G., & Seifritz, E. (2017). Resting state brain network function in major depression-depression symptomatology, antidepressant treatment effects, future research. *Journal of Psychiatric Research, 92*, 147-159. http://dx.doi.org/10.1016/j.jpsychires.2017.04.007

Branson-Potts, H. (2018, December 23). A young pastor preached about depression, then killed himself. His widow wants to help others by talking about it. *Los Angeles Times*. https://www.latimes.com/local/lanow/la-me-ln-pastor-suicide-20181223-story.html

Brantley, M. (2019, November 1). Accused former Arkansas pastor commits suicide in Florida. *Arkansas Times*. https://arktimes.com/arkansas-blog/2019/11/01/accused-former-arkansas-pastor-commits-suicide-in-florida

Breaker, R. R. (2011). *The importance of the blood of Jesus Christ: The blood of Jesus salvation*. CreateSpace.

Breen, D. (2013, December 11). Former pastor Isaac Hunter remembered as gifted, flawed man of God. *Orlando Sentinel*. https://www.orlandosentinel.com/news/os-xpm-2013-12-11-os-isaac-hunter-suicide-shot-himself-20131211-story.html

Brekus, C. A. (1996). Harriet Livermore, the pilgrim stranger: Female preaching and Biblical feminism in early-nineteenth-century America. *Church History, 65*(3), 389-404. https://www.jstor.org/stable/3169937

Briggs, M. (2019, September 23). *Why are pastors depressed? A look at the research*. Church Leaders. https://churchleaders.com/news/359562-why-are-pastors-depressed-a-look-at-the-research.html

Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health, 21*(1), 87-108.

Brody, D. J., Pratt, L. A., & Hughes, J. P. (2018). *Prevalence of depression among adults aged 20 and over: United States, 2013-2016* (NCHS Data Brief No. 303). Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/data/databriefs/db303.pdf

Brohan, E., Gauci, D., Sartorius, N., & Thornicroft, G. (2011). Self-stigma, empowerment, and perceived discrimination among people with bipolar disorder or depression in 13 European countries: The GAMIAN-Europe study. *Journal of Affective Disorders, 129*, 56-63. https://doi.org/10.1016/S0140-6736(08)61817-6

Brown, L. (2019, October 29). Florida pastor kills himself after teen accuses him of raping her 100 times. *New York Post*. https://nypost.com/2019/10/29/florida-pastor-kills-himself-after-teen-accuses-him-of-raping-her-over-100-times/

Bryant, F. (2018, March 30). *You can't "pray away" a mental health condition*. National Alliance on Mental Illness. https://www.nami.org/Blogs/NAMI-Blog/March-2018/You-Can-t-Pray-Away%E2%80%9D-a-Mental-Health-Condition

Burns, D. D. (1999). *The feeling good handbook*, (2nd ed.). Penguin Group

Burrows, R. (2000). Ontology vs. epistemology: The philosophical dynamic driving Edward Abbey's *Desert solitaire*. *Western American Literature, 35*(3), 284-297. https://doi.org/10.1353/wal.2000.0020

Buschmann, T., Horn, R. A., Blankenship, V. R., García, Y. E., & Bohan, K. B. (2018). The relationship between automatic thoughts and irrational beliefs predicting anxiety and depression. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 36*, 137-162.

Bussing, A., Frick, E., & Jacobs, C. (2016). Health and life satisfaction of Roman Catholic pastoral workers: Private prayer as a greater impact than public prayer. *Pastoral Psychology, 65*, 89-102. https://doi.org/10.3390/rel11040178

Cadge, W., Stroud, I. E., Palmer, P. K., Fitchett, G., Haythorn, T., & Clevenger, C. (2020). Training chaplains and spiritual caregivers: The emergence and growth of chaplaincy programs in theological education. *Pastoral Psychology, 69*, 187-208. https://doi.org/10.1007/s11089-020-00906-5

Cafferata, G. (2020). Gender, judicatory respect, and pastors' well-being in closing churches. *Review of Religious Research, 62*, 369-387. https://doi.org/10.1007/s13644-020-00414-1

Cameron, A. (2006). Clergy spiritually exhausted, stressed out: A new report shows Canadian ministry is "in crisis." *The Presbyterian Record, 130*(4), 10.

Campbell, A. D. (2021). Clergy perceptions of mental illness and confronting stigma in congregations. *Religions, 12*, 1-14. https://doi.org/10.3390/rel12121110

Capstick, T. (2018). Resilience. *ELT Journal, 72*(2), 210-213. https://doi.org/10.1093/elt/ccx068

Carothers, S. S., Borkowski, J. G., Lefever, J. B., & Whitman, T. L. (2005). Religiosity and the socioemotional adjustment of adolescent mothers and their children. *Journal of Family Psychology, 18*(2), 263-275. https://psycnet.apa.org/doi/10.1037/0893-3200.19.2.263

Centers for Disease Control and Prevention. (2018). *Fatal injury reports*. https://www.cdc.gov/injury/wisqars/fatal.html

Centers for Disease Control and Prevention. (2020). *Suicide data and statistics*. https://www.cdc.gov/suicide/suicide-data-statistics.html

Chan, K., & Wong, M. (2018). Experience of stress and coping strategies among pastor's wives in China. *Journal of Pastoral Care & Counseling, 72*(3), 163-171. https://doi-org.ezproxy.liberty.edu/10.1177/1542305018782518

Chan, Z. C., Fung, Y., & Chien, W. (2013). Bracketing in phenomenology: Only undertaken in the data collection and analysis process. *The Qualitative Report, 18*(30), 1-9. https://doi.org/10.46743/2160-3715/2013.1486

Chandler, D. J. (2009). Pastoral burnout and the impact of personal spiritual renewal, rest-taking, and support system practices. *Pastoral Psychology, 58*(3), 273-287. https://link.springer.com/article/10.1007/s11089-008-0184-4

Chandler, D. J. (2019, September 11). Jarrid Wilson tweeted hope before tragic death. *Baptist Press*. https://www.baptistpress.com/resource-library/news/jarrid-wilson-tweeted-hope-before-tragic-death/

Chavez, B. C. (2021). *Lived experiences of assemblies of God pastors with regards to leadership style, demands, stressors, and ministry burnout* [Doctoral dissertation, Liberty University]. ProQuest Dissertations and Theses Global.

Chen, Y.-L., Pan, A.-W., Hsiung, P.-C., Chung, L., Lai, J.-S., Gau, S. S. F., & Chen, T.-J. (2015). Life adaptation skills training (LAST) for persons with depression: A randomized controlled study. *Journal of Affective Disorders, 185*, 108-114.

Chiba, S., Numakawa, T., Ninomiya, M., Richards, M. C., Wakabayashi, C., & Kunugi, H. (2012). Chronic restraint stress causes anxiety-and depression-like behaviors, downregulates glucocorticoid receptor expression, and attenuates glutamate release induced by brain-derived neurotropic factor in the prefrontal cortex. *Progress in Neuro-Psychopharmacology & Biological Psychiatry, 39*, 112-119.

Chida, Y., Hamer, M., Wardle, J., & Steptoe, A. (2008). Do stress-related psychosocial factors contribute to cancer incidence and survival? *Natural Reviews Clinical Oncology, 5*, 466-475. https://doi.org/10.1038/ncponc1134

Chiles, J. A., Stroshal, K. D., & Roberts, L. W. (2018). *Clinical manual for assessment and treatment of suicidal patients*. American Psychiatric Association Publishing.

Choo, C. C., Harris, K. M., Chew, P. K. H., & Ho, R. C. (2019). Clinical assessment of suicide risk and suicide attempters' self-reported suicide intent: A cross sectional study. *PloS ONE, 14*(7), 1-11. https://doi.org/10.1371/journal.pone.0217613

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rusch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine, 45*, 11-27.

Clooney, F. X. (2018). Reading religiously across religious borders: A method for comparative study. *Religions, 9*(2), 1-12. https://doi.org/10.3390/rel9020042

Clough, B. A., March, S., Leane, S., & Ireland, M. J. (2019). What prevents doctors from seeking help for stress and burnout? A mixed-methods investigation among metropolitan and regional-based Australian doctors. *Journal of Clinical Psychology, 75*, 418-432. https://doi.org/10.1002/jclp.22707

Cole, B. P., & Ingram, P. B. (2020). Where do I turn for help? Gender role conflict, self-stigma, and college men's help-seeking for depression. *Psychology of Men & Masculinities, 21*(3), 441-452. https://doi.apa.org/doi/10.1037/men0000245

Coleman, S. J., Stevelink, S. A. M., Hatch, S. L., & Denny, J. A. (2017). Stigma-related barriers and facilitators to help seeking for mental health issues in the armed forces: A systematic review and thematic synthesis of qualitative literature. *Psychological Medicine, 47*(11), 1880-1892. https://doi.org/10.1017/S0033291717000356

Conner, T. S., Tennen, H., Fleeson, W., & Barrett, L. F. (2009). Experience sampling methods: A modern idiographic approach to personality research. *Social Personal Psychology Compass, 3*(3), 292-313.

Connor, K. M., & Davidson, J. R. (2003). Development of a new resilience scale: The Connor-Davidson resilience scale (CD-RISC). *Depression and Anxiety, 18*, 76-82.

Cook Funeral & Cremation Services. (n.d.). *Rev. Dale R. Cross Sr obituary*. https://www.cookcares.com/obituaries/Dale-Cross/#!/Obituary

Coombs, T. (2005). *Australian mental health outcomes and classification network: Mental health inventory training manual*. NSW Institute of Psychiatry. https://www.amhocn.org/sites/default/files/publication_files/mhi_manual.pdf

Cooper-White, P. (2006). Shared wisdom: Use of the self in pastoral care and counseling. *Pastoral Psychology, 55*, 233-241.

Cornally, N., & McCarthy, G. (2011). Help-seeking behaviour: A concept analysis. *International Journal of Nursing Practice, 17*(3), 280-288. https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1440-172X.2011.01936.x

Corrigan, P. W., Bink, A. B., Fokuo, J. K., & Schmidt, A. (2015). The public stigma of mental illness means a difference between you and me. *Psychiatry Research, 226*, 186-191.

Costello, J., Hays, K., & Gamez, A. M. (2020). Using mental health first aid to promote mental health in churches. *Journal of Spirituality in Mental Health, 23*(4), 381-392. https://doi-org.ezproxy.liberty.edu/10.1080/19349637.2020.1771234

Court, D. (2018). *Qualitative research and intercultural understanding: Conducting qualitative research in multi-cultural settings*. Routledge.

Crary, D. (2020, February 19). *Stresses multiply for many U.S. clergy: "We need help too."* RNS Religion News Service. https://religionnews.com/2020/02/19/stresses-multiply-for-many-us-clergy-we-need-help-too/

Craven, S. (2012). *A resource for pastors and counselors: Ministering to spiritual and emotional needs of those in ministry* [Doctoral Dissertation, Liberty Baptist Theological Seminary.] ProQuest Dissertations and Theses Global.

Croft, B., & Croft, C. (2013). *The pastor's family: Shepherding your family through the challenges of pastoral ministry*. Zondervan

Crowther, S., Ironside, P., Spence, D., & Smythe, L. (2017). Crafting stories in hermeneutic phenomenology research: A methodological device. *Phenomenology Methods, 27*(6), 826-835. https://doi.org/10.1177/1049732316656161

Dai, Z., Li, Q., Yang, G., Wang, Y., Lie, Y., Zheng, Z., Tu, Y., Yang, S., & Yu, B. (2019). Using literature-based discovery to identify candidate genes for the interaction between myocardial infarction and depression. *BMC Medical Genetics, 20*(1), 3-10. https://doi.org/10.1186/s12881-019-0841-8

Daniel, J. (2012). *Sampling essentials: Practical guidelines for making sampling choices*. SAGE.

Daskalakis, N. P., Bagot, R. C., Parker, K. J., Vinkers, C. H., & de Kloet, E. R. (2013). The three-hit concept of vulnerability and resilience: Toward understanding adaption to early-life adversity outcome. *Psychoneuroendocrinology, 38*(9), 1858-1873. https://doi.org/10.1016/j.psyneuen.2013.06.008

David, D., Cotet, C., Matu, S., Mogoase, C., & Stefan, S. (2018). 50 years of rational-emotive and cognitive-behavioral therapy: A systematic review and meta-analysis. *Journal of Clinical Psychology, 74*, 304-318.

Davidson, P., & Page, K. (2012). Research participation as work: Comparing the perspectives of researchers and economically marginalized populations. *American Journal of Public Health, 102*(7), 1254-1259. https://www.ncbi.nlm.nih.gov/pmc/articles /PMC3478002/pdf/AJPH.2011.300418.pdf

Deyoung, K. (2019, August 26). *Should women preach in our churches?* The Gospel Coalition. https://www.thegospelcoalition.org/blogs/kevin-deyoung/women-preach-churches/

Di Giuseppe, M., & Perry, C. J. (2021). The hierarchy of defense mechanisms: Assessing defense functioning with the defense mechanisms rating scales q-sort. *Frontiers in Psychology, 12*, 1-12. https://www-ncbi-nlm-nih-gov.ezproxy.liberty.edu/pmc/articles/PMC8555762/

Doolittle, B. R. (2015). Burnout, compassion fatigue, and job satisfaction among hospital chaplains: A systematic review. In *Research in the Social Scientific Study of Religion*. Brill. https://doi.org/10.1163/97Sg004299436_013

Drapalski, A. L., Lucksted, A., Perrin, P. B., Aakre, J. M., Brown, C. H., DeForge, B. R., & Boyd, J. E. (2013). A model of internalized stigma and its effects on people with mental illness. *Psychiatric Services, 64*(3), 264-269. https://doi.org/10.1176/appi.ps.001322012

Dryden, W. (2013). On rational beliefs in rational emotive behavior therapy: A theoretical perspective. *Journal of Rational-Emotive & Cognitive-Behavioral Therapy, 31*, 39-48.

Duckworth, A. L., Gendler, T. A., & Gross, J. J. (2016). Situational strategies for self-control. *Perspectives on Psychological Scient, 11*(1), 35-55. https://doi.org/10.1177/1745691615623247

Duckworth, A. L., & Yeager, D. S. (2015). Measurement matters: Assessing personal qualities other than cognitive ability for educational purposes. *Educational Research, 44*(4), 237-251.

Due, N., & Due, K. (2018). Courage and comfort for pastors in need. *Lutheran Theological Journal, 52*(3), 128.

Durand-Zaleski, I., Scott, J., Rouillon, F., & Leboyer, M. (2012). A first national survey of knowledge, attitudes and behaviors towards schizophrenia, bipolar disorders, and autism in France. *BMC Psychiatry, 12*(128), 1-8. http://www.biomedcentral.com/1471-244X/12/128

Dutta, A., McKie, S., & Deakin, J. F. (2016). Resting state networks in major depressive disorder. *Psychiatry Research: Neuroimaging, 224*, 139-151. http://dx.doi.org/10.1016/j.psychresns.2014.10.003

Earls, A. (2017). *How old are America's pastors?* Lifeway Research. https://lifewayresearch.com/2017/03/09/how-old-are-americas-pastors/

Earls, A. (2022, January 11). *U.S. pastors identify their greatest needs*. Lifeway Research. https://research.lifeway.com/2022/01/11/u-s-pastors-identify-their-greatest-needs/

Edersheim, A. (2003). *The life and times of Jesus the Messiah*. Packard Technologies. (Originally published c.a. 1825-1889). https://ccel.org/ccel/e/edersheim/lifetimes/cache /lifetimes.pdf

Edmunds, H. (1999). *The focus group research handbook*. McGraw Hill.

Edwards, J. (2011). *Sinners in the hands of an angry God* [Sermon]. (Original work published July 8, 1741). https://ccel.org/ccel/edwards/sermons/sermons.sinners.html?queryID=4025938&resultID=126 557

Edwards, J. L., & Crisp, D. A. (2017). Seeking help for psychological distress: Barriers for mental health professionals. *Australian Journal of Psychology, 69*, 218-225. https://doi.org/10.1111/ajpy.12146

Elo, S., Kaariainen, M., Kanste, O., Polkki, T., Utriainen, K., & Kyngas, H. (2014). Qualitative content analysis: A focus on trustworthiness. *SAGE Journals, 4*(1), 1-10. https://doi.org/10.1177/2158244014522633

Elraz, H. (2018). Identity, mental health, and work: How employees with mental health conditions recount stigma and the pejorative discourse of mental illness. *Human Relations, 71*(5), 722-741.

Endress, M. (2019). The theoretical claims of the social construction of reality. In Pfadenhauer, M., & Knoblauch, H. (Eds.), *Social constructivism as paradigm?* (pp. 45-64). Routledge.

Enomoto, J., Nakazawa, J., Mizuno, Y., Shirai, T., Ogawa, J., & Niwa, K. (2012). Psychosocial factors influence mental health in adults with congenital heart disease. *Journal of the Japanese Circulation Society, 77*(3). https://doi.org/10.1253/circj.CJ-12-0716

Eskin, M. (2012). *Problem solving therapy in the clinical practice*. Elsevier Inc.

Faber, J., & Fonseca, L. M. (2014). How sample size influences research outcomes. *Dental Press Journal of Orthodontics, 19*(4), 27-29. https://www.ncbi.nlm.nih.gov/pmc/articles /PMC4296634/

Fabrega, H. (1991). The culture and history of psychiatric stigma in early modern and modern western societies: A review of the recent literature. *Comprehensive Psychiatry, 32*(2), 97-119.

Faithlife. (2021). *2021 pastoral mental health report*. https://faithlife.com/ministry-resources

Farr, B., & Kotan, K. (2016). *The necessary nine: Things effective pastors do differently*. Abingdon Press.

Federal Emergency Management Agency. (2020). *Tip sheets: engaging faith communities*. https://www.fema.gov/sites/default/files/2020-03/fema_faith-communities_protestant-leaders_1.pdf

Fee, C. (2018). *Causes of burnout among church leaders: A qualitative phenomenological study of pastors* [Unpublished doctoral dissertation, Walden University]. Walden Dissertations and Doctoral Studies.

Feinson, M. C., & Meir, A. (2015). Exploring mental health consequences of childhood abuse and the relevance of religiosity. *Journal of Interpersonal Violence, 30*(3), 499-521. https://doi.org/10.1177%2F0886260514535094

Felix, M. (1974). *The octavius of Minucius Felix* (Wallais, R.E., Trans). (Original work published ca. 210-230). http://www.ccel.org/schaff/anf04.html

Fellingham, G. W., McBride, H., Tolley, D., & Lyon, J. L. (2000). Statistics on suicide and LDS church involvement in males age 15-34. *Brigham Young University Studies, 39*(2), 173-180. https://www.jstor.org/stable/43044992?seq=1

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology, 58*(11), 1433-1441.

Florida Baptist Convention Administration. (2019, March 15). *2018 pastors conference-session 3*. Florida Baptist Convention. https://flbaptist.org/2018-pastors-conference-session-3/

Fox, D. (2014). *The clinician's guide diagnosis & treatment of personality disorders*. PESI Publishing and Media.

Francis, L., Laycock, P., & Brewster, C. (2017). Work-related psychological wellbeing: Testing the balanced affect model among Anglican clergy. *Religions, 8*(7), 2-11. https://doi.org/10.3390/rel8070118

Frenk, S. M. (2014). Beyond clergy: Congregations' sponsorship of social services for people with mental disorders. *Administrative Policy Mental Health, 41*, 146-457. https://doi.org/10.1007/s10488-012-0443-7

Friese, M., Frankenbach, J., Job, J., & Loschelder, D. D. (2017). Does self-control training improve self-control? A meta-analysis. *Perspectives on Psychological Science, 12*(6), 1077-1099. https://doi.org/10.1177/174569167697076

Fsharp. (2021, December 31). *Female pastor reportedly commit suicide*. Nobelie. https://nobelie.com/female-pastor-reportedly-commit-suicide/

Furniss, G. M. (2013). Spirituality and hope in pastoral care. *Journal of Pastoral Theology, 23*(2), 4-1-4-17. https://doi.org/10.1179/jpt.2013.23.2.005

Gangel, K. O. (1994). *Feeding & leading: A practical handbook on administration in churches and Christian organizations*. Victor Books.

Gani, N. I. A., Rathakrishnan, M., & Krishnasamy, H. N. (2020). A pilot test for establishing validity and reliability of qualitative interview in the blended learning English proficiency course. *Journal of Critical Reviews, 7*(5), 140-143.

García, F. E., Páez, D., Reyes-Reyes, A., & Álvarez, R. (2017). Religious coping as moderator of psychological responses to stressful events: A longitudinal study. *Religions*, *8*(4), 62. https://doi.org/10.3390/rel8040062

Gassin, E. (2020). *Using MAXQDA for an interpretative phenomenological analysis of children's experience with communion MAXQDA users conference*. Research Gate. https://www.researchgate.net/publication/354169549_Using_MAXQDA_for_an_Interpretative_Phenomenological_Analysis_of_Children%27s_Experience_with_Communion_MAXQDA_Users_Conference_2020

Gaultiere, B. (n.d.). *The lonely leader*. Soul Shepherding. https://www.soulshepherding.org/the-lonely-leader/

Gill, C., Packer, J., & Ballantyne, R. (2019). Spiritual retreats as a restorative destination: Design factors facilitating restorative outcomes. *Annals of Tourism Research, 79*, 1-13. https://doi.org/10.1016/j.annals.2019.102761

Gillard, S., Gibson, S. L., Holley, J., & Lucock, M. (2014). Developing a change model for peer worker interventions in mental health services: A qualitative research study. *Epidemiology and Psychiatric Sciences, 24*(5), 435-445. doi:10.1017/S2045796014000407

Glanville, J. A., & Dryer, Y. (2013). Spousal rape: A challenge for pastoral counsellors. *HTS Teologiese Studies, 69*(1), 1-12. https://doi.org/10.4102/hts.v69i1.1935

Glanz, K., Rimer, B. K., & Viswanath, K. (Eds.). (2015). *Health behavior: Theory, research, and practice*. John Wiley & Sons.

Glen, S. (n.d.). *Non-response bias: Definition, examples*. Statistics How To. https://www.statisticshowto.com/non-response-bias/

Gold, K. J., Andrew, L. B., Goldman, E. B., & Schwenk, T. L. (2016). "I would never want to have a mental diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *General Hospital Psychiatry, 43*, 51-57. http://dx.doi.org/10.1016/j.genhosppsych.2016.09.004

Goldberg, D. (2008, October 27). Goodbye to the supernatural God. *The Guardian*. https://www.theguardian.com/commentisfree/belief/2008/oct/27/philosophy-religion

Gotranscript.com. (n.d.). *Confidential transcription services*. https://gotranscript.com/confidential-transcription-services

Graham, B. (2016, September 8). *Billy Graham-The devil and demons-Dallas TX 1971*. YouTube. https://www.youtube.com/watch?v=lA5KUfzkfYE&t=153s

Green, L. C. (2016, January 12). *Former pastors report lack of support led to abandoning pastorate*. Lifeway Research Group. https://lifewayresearch.com/2016/01/12/former-pastors-report-lack-of-support-led-to-abandoning-pastorate/

Greene-Shortridge, T. M., Britt, T. W., & Castro, C. A. (2007). The stigma of mental health problems in the military. *Military Medicine, 172*(2), 157-162. https://doi.org/10.7205/MILMED.172.2.157

Grohol, J. M. (2018, July 8). *When depression lies & you feel like a failure*. Psych Central. https://psychcentral.com/blog/when-depression-lies-you-feel-like-a-failure/

Grohol, J. M. (2019, June 24). *15 common cognitive distortions.* Psych Central. https://psychcentral.com/lib/15-common-cognitive-distortions/

Grosch, W. N., & Olsen, D. O. (2000). Clergy burnout: An integrative approach. *Journal of Clinical Psychology/In Session, 56*, 619-635.

Gunathilaka, H. J., Vitharana, P., Udayanga, L., & Gunathilaka, N. (2019). Assessment of anxiety, depression, stress, and associated psychological morbidities among patients receiving any treatment for different health issues: First study from Sri Lanka. *BioMed Research International*, 1-11. https://doi.org/10.1155/2019/2940836

Hackney, C. H., & Sanders, G. S. (2003). Religiosity and mental health: A meta-analysis of recent studies. *Journal for the Scientific Study of Religion, 42*(1), 43-55. https://core.ac.uk/download/pdf/189674589.pdf

Hadjistavropoulos, T., & Smythe, W. (2001). Elements of risk in qualitative research. *Ethics & Behavior, 11*(2), 163-174. https://doi.org/10.1207/S15327019EB1102_4

Hahn, P. D. (2019). *Madness and genetic determinism: Is mental illness in our genes*? Palgrave Macmillan. https://doi.org/10.1007/978-3-030-21866-9

Haitao, L. (2019, July 20). *Exhausted by party control, official Christian pastor commits suicide*. PIME Asian News. https://www.asianews.it/news-en/Exhausted-by-Party-control,-official-Christian-pastor-commits-suicide-47572.html

Hall, E. R. (2021). "Maybe Jesus was suicidal too": A United Church of Christ pastor reflects on his suicide attempt. *Religions, 12*(11), 930. https://doi.org/10.3390/rel12110930

Hall, K. (2017). The critical role of mentoring for pastoral formation. *Journal of Applied Christian Leadership, 11*(1), 42.53. https://digitalcommons.andrews.edu/jacl/vol11/iss1/3?utm_source=digitalcommons.andrews.edu%2Fjacl%2Fvol11%2Fiss1%2F3&utm_medium=PDF&utm_campaign=PDFCoverPages

Halloran, K. (2013, October 22). *Christian ministry burnout: Prevention, signs, statistics, and recovery*. Leadership Resources. https://www.leadershipresources.org/blog/christian-ministry-burnout-prevention-signs-statistics-recovery/

Hammer, J. H. (2016). *Mental health professions career test*. DrJosephHammer.com. http://drjosephhammer.com/psych-grad-school/the-mental-health-professions-career-test/fine-print-for-mhpct/

Hanafi, A. (2016, February 1). Pastor accused of diverting church funds commits suicide. *PUNCH*. https://punchng.com/pastor-accused-of-diverting-church-funds-commits-suicide/

Hanna, P. (2012). Using internet technology (such as Skype) as a research medium: A research note. *Qualitative Research, 12*, 239-242.

Harmon, B. E., Strayhorn, S., Webb, B. L., & Herbert, J. R. (2018). Leading God's people: Perceptions of influence among African American pastors. *Journal of Religion and Health, 57*, 1509-1523. https://doi.org/10.1007/s10943-018-0563-9

Harris, J. I., Nievow, T., Choi, A., Engdahl, B., Nguyen, X. V., & Thuras, P. (2015). Client report of spirituality in recovery from serious mental illness. *Psychology of Religion and Spirituality, 7*(2), 142-149. https://doi.org/10.1037/a0038538

Hart, C. W., & Div, M. (2010). Present at the creation: The clinical pastoral movement and the origins of the dialogue between religion and psychiatry. *Journal of Religion and Health, 49*(4), 536-546. www.jstor.org/stable/40961605

Härtl, G. (2001, October 4). *The World Health Report 2001: Mental disorders affect one in four people*. World Health Organization. https://www.who.int/whr/2001/media_centre/press_release/en/

Haug, I. E. (1999). Boundaries and the use and misuse of power and authority: Ethical complexities for clergy psychotherapists. *Journal of Counseling & Development, 77*(4), 411-417.

Havermans, B. M., Boot, C. R. L., Hoekstra, T., Houtman, I. L. D., Brouwers, E. P. M., Anema, J. R., & Van der Beck, A. J. (2018). The association between exposure to psychosocial work factors and mental health in older employees, a 3-hear follow-up study. *International Archives of Occupational and Environmental Health, 91*, 57-66. https://doi.org/10.1007/s00420-017-1261-8

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2011). *Acceptance and commitment therapy: The process and practice of mindful change* (2nd ed.). Guilford Publications.

Heck, A., Drumm, R., McBride, D., & Sedlacek, D. (2018). Seventh-day Adventist clergy: Understanding stressors and coping mechanisms. *Review of Religious Research, 60*(1), 115-123. https://doi.org/10.1007/s13644-017-0312-7

Heinz, F. (2019, May 3). *Cedar Hill pastor died of suicide ahead of house fire that killed daughters, wife*. NBCDFW. https://www.nbcdfw.com/news/local/cedar-hill-pastor-died-of-suicide-ahead-of-house-fire-that-killed-daughters-wife/247829/

Hendron, J. A., Irving, P., & Taylor, B. J. (2014). Clergy stress through working with trauma: A qualitative study of secondary impact. *Journal of Pastoral Care & Counseling*, *68*(4), 1-14. https://doi.org/10.1177/154230501406800404

Henry, M. (2003). *Concise commentary on the Bible*. (Original work published 1706). https://ccel.org/ccel/h/henry/mhcc/cache/mhcc.pdf.

Heppner, P. P., Wampold, B. E., Owen, J., & Wang, K. T. (2015). *Research design in counseling* (4th ed). Cengage Learning.

Herman, J. L. (1997). *Trauma and recovery*. Basic Books.

Hesse-Biber, S. N., & Griffin, A. J. (2012). Internet-mediated technologies and mixed methods research: Problems and prospects. *Journal of Mixed Methods Research, 7*, 43-61.

Heyes, S., Pratt, W. S., Rees, E., Dahimene, S., Ferron, L., Owen, M. J., & Dolphin, A. (2015). Genetic disruption of voltage-gated calcium channels in psychiatric and neurological disorders. *Progress in Neurobiology, 134*, 36-54. http://dx.doi.org/10.1016/j.pneurobio.2015.09.002

Hilgemann, B. (2019, July 24). *20 things I wish I knew before becoming a pastor*. ProPreacher.com. https://www.propreacher.com/20-things-wish-knew-becoming-pastor/

Holdman, J. (2020, May 9). SC megachurch pastor dies of apparent self-inflicted gunshot while target shooting. *The Post and Courier*. https://www.postandcourier.com/news/sc-megachurch-pastor-dies-of-apparent-self-inflicted-gunshot-while-target-shooting/article_3cc3e2e2-9220-11ea-867b-0bd1bda308b8.html

Horrigan-Kelly, M., Millar, M., & Dowling, M. (2016). Understanding the key tenets of Heidegger's philosophy for interpretative phenomenological research. *International Journal of Qualitative Methods, 15*(1). https://doi.org/10.1177%2F1609406916680634

Horsfall, J., Cleary, M., & Hunt, G. E. (2010). Stigma in mental health: Clients and professionals. *Issues in Mental Health Nursing, 31*(37), 450-455. https://doi.org/10.3109/01612840903537167

Hough, H., Proeschold-Bell, R. J., Liu, X., Weisner, C., Turner, E., & Yao, J. (2019). Relationships between Sabbath observance and mental, physical, and spiritual health in clergy. *Pastoral Psychology, 68*, 171-193. https://doi.org/10.1007/s11089-018-0838-9

Houghton, F., Keane, N., Murphy, N., Houghton, S., & Dunne, C. (2010). Tertiary level students and the mental health index (MHI-5) in Ireland. *Irish Journal of Applied Social Studies, 10*(1), 1-10. https://doi.org/10.21427/D75Q81

Howsepian, A. A. (2015). Is Christianity bad for your health? *The Christian Research Journal, 38*(2). http://www.equip.org/PDF/JAF1382.pdf

Hunsaker, S., Chen, H.-C., Maughan, D., & Heaston, S. (2015). Factors that influence development of compassion fatigue, burnout, and compassion satisfaction in emergence department nurses. *The Journal of Nursing Scholarship, 47*(2), 186-194. https://doi.org/10.1111/jnu.12122

Illers, E. (2021, December 2). *Florida pastor accused of sex crimes involving two Tennessee sisters commits suicide*. WKRN. https://www.wkrn.com/news/local-news/murfreesboro/florida-pastor-accused-of-molesting-two-tennessee-sisters-commits-suicide/

Isacco, A., Sahker, E., Krinock, E., Sim, W., & Hamilton, D. (2016). How religious beliefs and practices influence the psychological health of Catholic priests. *American Journal of Men's Health, 10*(4), 325-337.

Jackson, S. (2014, May 4). Young Waukee church faces pastor's suicide. *Des Moines Register*. https://www.desmoinesregister.com/story/news/2014/05/05/waukee-church-faces-pastor-suicide/8711207/

Jackson-Jordan, E. A. (2013). Clergy burnout and resilience: A review of the literature. *Journal of Pastoral Care & Counseling, 67*(1), 36-40.

Jacob, K. S. (2013). Psychosocial adversity and mental illness: Differentiating distress, contextualizing diagnosis. *Indian Journal of Psychiatry, 55*(2), 106-110.

Jagosh, J., Macaulay, A. C., Pluye, P., Salsberg, J., Bush, P. L., Henderson, J., Sirett, E., Wong, G., Cargo, M., Herbert, C. P., Seifer, S. D., Green, L. W., & Greenhalgh, T. (2012). Uncovering the benefits of participatory research: Implications of a realist review for health research and practice. *The Milbank Quarterly, 90*(2), 311-346. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3460206/?report=reader#_ffn_sectitle

Jamaica Observer. (2014, April, 1). *T&T pastor kills brother, commits suicide*. https://www.jamaicaobserver.com/news/tt-pastor-kills-brother-commits-suicide/

Jang, Y., Park, N. S., Yoon, H., Ko, J. E., Jung, H., & Chiriboga, D. A. (2017). Mental health literacy in religious leaders: A qualitative study of Korean American clergy. *Health and Social Care in Community, 25*(2), 385-393.

Johnson, D. (2016). *An analysis of causes and impacts of depression in pastors* [unpublished doctoral dissertation, Liberty University]. https://digitalcommons.liberty.edu/doctoral/1288/

Jones, L. (2018). Pastoral power and the promotion of self-care. *Sociology of Health & Illness, 40*(6), 988-1004. https://doi.org/10.1111/1467-9566.12736

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). "Mental health literacy": A survey of the public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment. *The Medical Journal of Australia, 166*(4), 182-186.

Joshi, A., & Phadke, K. (2018). Overview of REBT theory. In A. Joshi & K. Phadke (Eds.). *Rational emotive behavior therapy integrated* (pp. 32-44). SAGE.

Kaptchuk, T. J. (2003). Effect of interpretative bias on research evidence. *BMJ, 326*, 1453-1455. https://doi.org/10.1136/bmj.326.7404.1453

Kaufman, E. A., McDonell, M. G., Cristofalo, M. A., & Ries, R. K. (2012). Exploring barriers to primary care for patients with severe mental illness: Frontline patient and provider accounts. *Issues in Mental Health Nursing, 33*(3), 172-180. https://doi.org/10.3109/01612840.2011.638415

Keener, C. S. (2011). *Miracles: The credibility of the New Testament accounts*. Baker Academic

Keller, T. (2019, January 25). *I feel trapped in my job-what should I do?* Desiring God. https://www.desiringgod.org/interviews/i-feel-trapped-in-my-job-what-should-i-do

Kelly, M. J., Dunstan, F. D., Lloyd, K., & Fone, D. L. (2008). Evaluating cut points for the MHI-5 and MSC using the GHQ-12: A comparison of five different methods. *BMC Psychiatry, 8*(10), 1-9. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2265280/pdf/1471-244X-8-10.pdf

Kennedy, L. (2020, February 20). *Inside Jonestown: How Jim Jones trapped followers and forced suicides.* History. https://www.history.com/news/jonestown-jim-jones-mass-murder-suicide

Kim, J. E., Zane, N. W., & Blozis, S. A. (2012). Client predictors of short-term psychotherapy outcomes among Asian and White American outpatients. *Journal of Clinical Psychology, 58*(12), 1287-1302. https://doi.org/10.1002/jclp.21905

King James Study Bible. (2017). *Thomas Nelson*. (Original work published 1988)

Kinnaman, D., Dahlstadt, I., Hawkings, A. L., Hochmuth, T., & Jacob, P. (2017). *The state of pastors*. https://www.barna.com/pastors2017/

Knox, J. (2003). *The first blast of the trumpet against the monstrous regiment of women* (Aber, E., Trans). Gutenberg.org (Original work published ca. 1505-1572). https://www.gutenberg.org/files/9660/9660-h/9660-h.htm

Koenig, H. G. (2010). Spirituality and mental health. *International Journal of Applied Psychoanalytic Studies, 7*(2), 116-122.

Koenig, H. G. (2018). *Religion and mental health: Research and clinical applications*. Academic Press. https://doi.org/10.1016/C2016-0-00979-8

Kolker, K. (2019, February 7). *Detectives: Pastor staged suicide to look like murder*. Wood TV. https://www.woodtv.com/news/kent-county/detectives-pastor-staged-suicide-to-look-like-murder/

Krech, V. (2012). Religious contacts in past and present times: Aspects of a research programme. *Religion, 42*(2), 191-213. https://doi.org/10.1080/0048721X.2012.642572

Krishna, R., Maithreyi, R., & Surapaneni, K. M. (2010). Research bias: A review for medical students. *Journal of Clinical and Diagnostic Research, 4*, 2320-2324.

Kristula, C. G. H. (2008). *Dispelling the last taboo: Helping clergy and congregations to care for persons and families who are living with mental illness* (Order No. 304652055) [Doctoral dissertation, Drew University]. ProQuest Dissertations and Theses Global.

Krstanoska-Blazeska, K., Thomson, R., & Slewa-Younan, S. (2021). Mental illness stigma and associated factors among Arabic-speaking religious and community leaders. *International Journal of Environmental Research and Public Health, 18*(7991), 1-13. https://doi.org/10.3390/ijerph18157991

Krupa, T., Kirsh, B., Cockburn, L., & Gewurtz, R. (2009). Understanding the stigma of mental illness in employment. *Work*, *33*, 413-425.

Kuckartz, U., & Radiker, S. (2019). *Analyzing qualitative data with MAXQDA: Text, audio, and video.* CORE. https://core.ac.uk/download/pdf/326762723.pdf

Kutcher, S., Wei, Y., & Congiglio, C. (2016). Mental health literacy: Past, present, and future. *The Canadian Journal of Psychiatry, 61*(3), 154-158.

LaMorte, W. W. (2019, September 9). *The theory of planned behavior*. Boston University School of Public Health. https://sphweb.bumc.bu.edu/otlt/MPH-modules/SB/BehavioralChangeTheories/BehavioralChangeTheories3.html

Lamothe, M., McDuff, P., Pastore, Y. D., Duval, M., & Sultan, A. (2018). Developing professional caregivers' empathy and emotional competencies through mindfulness-based stress reduction (MBSR): Results of two proof-of-concept studies. *BMJ Open, 8*(1). https://bmjopen-bmj-com.ezproxy.liberty.edu/content/8/1/e018421

Lane, B. (2015). *2015 pastor survey results*. Expastors.com. http://www.expastors.com/pastor-survey/

Langberg, D. (2020). *Redeeming power: Understanding authority and abuse in the church*. Brazos Press.

Largent, E. A., & Lynch, H. F. (2017a). Paying research participants: Regulatory uncertainty, conceptual confusion, and a path forward. *Yale Journal of Health Policy, Law, and Ethics, 17*(1), 61-141. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5728432/pdf/nihms848393.pdf

Largent, E. A., & Lynch, H. F. (2017b). Paying research participants: The outsized influence of "undue influence." *IRB, 38*(4), 1-9. https://www.ncbi.nlm.nih.gov/pmc/articles /PMC5640154/#__ffn_sectitle

Larkin, C. (1918). *The greatest book on dispensational truth in the world*. The Clarence Larkin Estate.

Larkin, M. (2020, April 25). *bottom-up, clusters of raw material, emerging patterns* [Comments on the video IPA community: brief introduction to 3 coding strategies in IPA]. YouTube. https://youtu.be/g3cz4Z2_GcE

Lasalvia, A., Zoppei, S., Bartel, T. V., Bonetto, C., Cristofalo, D., Wahlbeck, K., Bacle, S. V., Audenhove, C. V., van Weeghel, J., Reneses, B., Germanavicius, A., Economou, M., Lanfredi, M., Ando, S., Sartorius, J., Lopez-Ibor, J. J., & Thornicraft, G. (2012). Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: A cross-sectional survey. *The Lancet, 381*(9860), 55-56. http://dx.doi.org/10.1016/S0140-6736(12)61379-8

Latoo, J., Mistry, M., & Dunne, F. J. (2013). Physical morbidity and mortality in people with mental illness. *British Journal of Medical Practitioners, 6*(3), 2-3.

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2*(3), 21-35. https://journals.sagepub.com/doi/10.1177/160940690300200303

Leavey, G. (2008). U.K. clergy and people in mental distress: Community and pattens of pastoral care. *Transcultural Psychiatry, 45*(1), 79-104.

Leavey, G. (2010). The appreciation of the spiritual in mental illness: A qualitative study of beliefs among clergy in the UK. *Transcultural Psychiatry, 47*(4), 571-590. https://doi.org/10.1177/1363461510383200

Leavey, G., Loewenthal, K., & King, M. (2016). Locating the social origins of mental illness: The explanatory models of mental illness among clergy from different ethnic and faith backgrounds. *Journal of Religion and Health, 55*, 1607-1622.

Lee, M. (2014, April 04). Pastor commits suicide after allegedly killing brother and running over nephew in car. *The Christian Post*. https://www.christianpost.com/news/pastor-commits-suicide-after-allegedly-killing-brother-and-running-over-nephew-in-car.html

Lee, M. (2019, July 31). Responding to Josh Harris's announcement. *Christianity Today*. https://www.christianitytoday.com/ct/2019/july-web-only/leaving-faith-church-christianity-falling-away-josh-harris.html

Lent, R. W. (2013). Social cognitive career theory. In Brown, S. D., Lent, R. W., & Lent, R. W. (Eds.), *Career development and counseling: Putting theory and research to work* (2nd ed.), pp.115-146). John Wiley & Sons, Incorporated.

Letizia, M. J. (2022). *A survey of mental health education, training, and preparation for Protestant ministers within the South Florida area* (Order No. 28964081). ProQuest Dissertations & Theses Global. (2656857849)

Lewis, C. S. (2002). Mere Christianity. In *The complete C.S. Lewis signature classics*. Harper One (Original work published in 1952).

Liberty University. (n.d.). *School of Behavioral Sciences Doctor of Education Community Care & Counseling dissertation handbook*. https://canvas.liberty.edu/courses/64251/modules/items/6851413

Lifeway. (2015). *Pastor protection research study*. http://lifewayresearch.com/wp-content/uploads/2015/08/Pastor-Protection-Quantitative-Report-Final.pdf

Lifeway. (2017). *Suicide and the Church*. http://lifewayresearch.com/wp-content/uploads/2017/09/Suicide-and-the-Church-Research-Study-Report.pdf

Lincoln, Y. S., & Guba, E. (1985). *Naturalistic inquiry*. SAGE.

Linehan, M. M., Comtois, K. A., Brown, M. Z., Heard, H. L., & Wanger, A. (2006). Suicide attempt self-injury interview (SASII): Development, reliability, and validity of a scale to assess suicide attempts and intentional self-injury. *Psychological Assessment, 18*(3), 303-312.

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine, 71*(12), 2150-2161. https://doi.org/10.1016/j.socscimed.2010.09.030

Lloyd, C. E. M. (2023). "Prayer is fine, but don't then quickly move on, as if you're done and dusted": How can the evangelical church better support those with mental illness? *Journal of Disability & Religion.* https://doi-org.ezproxy.liberty.edu/10.1080/23312521.2023.2173712

Lloyd, C. E. M., & Panagopoulos, M. C. (2022). 'Mad, bad, or possessed'? Perceptions of self-harm and mental illness in evangelical Christian communities. *Pastoral Psychology, 71*, 291-311. https://doi.org/10.1007/s11089-022-01005-03

London, H. B., & Wiseman, N. B. (2011). *Pastors at greater risk*. Baker Books.

Lopez, S. J., Floyd, K. R., Ulven, J. C., & Snyder, C. R. (2000). Hope therapy: Helping clients build a house of hope. In Snyder, C.R. (Ed.), *Handbook of hope: Theory, measures & applications* (pp. 123-150). Academic Press.

Lount, M., & Hargie, O. D. W. (1997). The priest as counsellor: An investigation of critical incidents in the pastoral work of Catholic priests. *Counseling Psychology Quarterly, 10*(3), 247-259. https://doi.org/10.1080/09515079708254177

Lovett, I. (2020, January 20). "It's like I got kicked out of my family." Churches struggle with mental health in the ranks. *The Wall Street Journal*. https://www.wsj.com/articles/its-like-i-got-kicked-out-of-my-family-churches-struggle-with-mental-health-in-the-ranks-11579547221

Lucksted, A., & Drapalski, A. L. (2015). Self-stigma regarding mental illness: Definitions, impacts, and relationship to societal stigma [Editorial]. *Psychiatric Rehabilitation Journal, 38*(2), 99-102. https://psycnet.apa.org/doi/10.1037/prj0000152

Luedtke, A. C., & Sneed, K. J. (2018). Voice of the clergy wife: A phenomenological study. *Journal of Pastoral Care & Counseling, 72*(1), 63-72. https://doi-org.ezproxy.liberty.ed/10.1177/1542305018762212

Lukachko, A., Myer, I., & Hankerson, S. (2015). Religiosity and mental health service utilization among African Americans. *The Journal of Nervous and Mental Disease, 203*(8), 578-582.

Luzon, I. N. (2019, January 30). *Pangasinan pastor found dead in apparent suicide*. Inquirer.net. https://newsinfo.inquirer.net/1079205/pangasinan-pastor-found-dead-in-apparent-suicide

Magee, D. (2014, February 13). New details: Popular pastor takes his own life in Dunkerton. *The Courier*. https://wcfcourier.com/news/local/new-details-popular-pastor-takes-his-own-life-in-dunkerton/article_47538534-443f-50eb-a849-1530c80728fe.html

Maier, S. F., & Seligman, M. E. P. (2016). Learned helplessness at fifty: Insights from neuroscience. *Psychological Review, 123*(4), 349-367. http://dx.doi.org/10.1037/rev0000033

Majid, M. A. A., Othman, M., Mohamad, S. F., Lim, S. A. H., & Yusof, A. (2017). Piloting for interviews in qualitative research: Operationalization and lessons learnt. *International Journal of Academic Research in Business and Social Sciences, 7*(4), 1073-1080.

Makin, G. A. (2005). *Understanding the turnover intentions of youth pastors* (Publication No. 3188228) [Doctoral dissertation, Regent University]. ProQuest Dissertations and Theses Global.

Manen, V. M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. The Althouse Press.

Maples, J. (2019, May 16). *Charismatic pastor suffering from depression leaps from bridge, commits suicide.* RC Reformation Charlotte. https://reformationcharlotte.org/2019/05/16/charismatic-pastor-suffering-from-depression-leaps-from-bridge-commits-suicide/

Marble Retreat. (n.d.). *Our story*. https://marbleretreat.org/about/#story

Marek, M. W. (2015, June 7). *Re: Which is more appropriate, phenomenology or grounded theory?* [Online forum message]. https://www.researchgate.net/post/Which_is_more_appropriate_phenomenology_or_grounded_theory#:~:text=

Marie, B. (2014, May 6). Iowa pastor George DB Antrim III commits suicide; Westwind church healing through communication. *Christian Today*. https://www.christiantoday.com/article/iowa.pastor.george.db.antrim.iii.commits.suicide.westwind.church.healing.through.communication/37242.htm

Martin, S. (2019, July 30). *Distraught Chinese pastor dies by suicide, calls it martyrdom*. Church Leaders. https://churchleaders.com/news/356311-distraught-chinese-pastor-chooses-suicide-calls-it-martyrdom.html

Marwaha, H., He, Z., Broome, M., Singh, S. P., Scott, J., Eyden, J., & Walke, D. (2014). How is affective instability defined and measured? A systematic review. *Psychological Medicine, 44*, 1793-1808.

Masenyama, M. (2019, September 24). Pastor commits suicide after walking in on cheating wife. *New Zimbabwe News*. https://www.newzimbabwe.com/pastor-commits-suicide-after-walking-in-on-cheating-wife/

McCain, M. R. C. (2017). *A grounded theory exploration of clergy's counseling referral practices in Black churche*s [Doctoral dissertation, University of Nebraska]. ProQuest Dissertations and Theses Global.

McClure, P. K., & Wilkinson, L. R. (2020). Attending substance abuse groups and identifying as spiritual but not religious. *Review of Religious Research, 62*, 197-218. https://doi.org/10.1007/s13644-020-00405-2

McGinnis, C. Z. A. (2015). Family ostracism in Christianity and counseling. *Journal of Psychology and Christianity, 34*(1), 79-83.

McKlveen, J. M., Myers, B., Flak, J. N., Bundzikova, J., Solomon, M. B., Seroogy, K. B., & Herman, J. P. (2013). Role of prefrontal cortex glucocorticoid receptions in stress and emotion. *Biological Psychiatry, 74*, 672-679. http://dx.doi.org/10.1016/j.biopsych.2013.03.024

McLean, G. (2015). An integrative professional theory and practice paper: Personal reflections from the journey through clinical pastoral education. *Journal of Pastoral Care & Counseling, 69*(4), 201-214. https://doi.org/10.1177/1542305015616100

McNaughten, J. R. (2015). *Confessions of a depressed Christian: How a pastor survived depression and how you can too*. Pennsylvania Ave. Press.

Melick, R. R. (1998). Women pastors: What does the Bible teach? *SBCLIFE*. http://www.sbclife.net/article/329/women-pastors-what-does-the-bible-teach

Melito. (2020). *Fragments of Melito of Sardis* (Donaldson, R., Trans.). Early Christian Writings. http://www.earlychristianwritings.com/melito.html (Original work published ca. 165-175 B.C.E.)

Mennin, D. S., Ellard, K. K., Fresco, D. M., & Gross, J. J. (2013). United we stand: Emphasizing commonalities across cognitive-behavioral therapies. *Behavior Therapy, 44*, 234-248. https://doi.org/10.1016/j.beth.2013.02.004

Mercer, J. (2013). Deliverance, demonic possession, and mental illness: Some considerations for mental health professions. *Mental Health, Religion, & Culture, 16*(6), 595-611.

Mercury News. (2011, May 4). Oakley pastor accused of fraud commits suicide, sheriff's office says. *The Mercury News*. https://www.mercurynews.com/2011/05/04/oakley-pastor-accused-of-fraud-commits-suicide-sheriffs-office-says/

Miguel, M. (2019, May 19). *What is acceptance and commitment therapy?* Betterhelp.com. https://www.betterhelp.com/advice/therapy/what-is-acceptance-and-commitment-therapy/

Milacci, F. (n.d.). *Watch: Credible qualitative research*. [Video]. Liberty University EdD Community Care and Counseling. https://canvas.liberty.edu/courses/64251/pages/watch-credible-qualitative-research?module_item_id=7861933

Miles, A., Proescholdbell, R. J., & Puffer, E. (2011). Explaining rural/non-rural disparities in physical health-related quality of life: A study of United Methodist clergy in North Carolina. *Quality Life Research, 20*, 807-815. https://doi.org/doi.10.1007/s11136-010-9817-z

Miles, M. B., Huberman, M. A., & Saldana, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). SAGE

Mirick, R., & Williams, M. (n.d.). *Risks & benefits*. SalemState.edu. https://elearning.salemstate.edu/courses/1110675/pages/risks-and-benefits

Moll, S., & O'Brien, K. (2009, February). Breaking the silence: The mental health of our clergy. *Presbyterian Record, 133*(2), 18-23. https://go-gale-com.ezproxy.liberty.edu/ps/i.do?p=ITOF&u=vic_liberty&id=GALE|A194473083&v=2.1&it=r&sid=ITOF&asid=a1af04f4

Monday, O. (2022, March 8th). Video: Pastor attempts suicide in Rivers State over his church not growing, house rent. *Grassroot Reporters.* https://www.grassrootreportersng.com/2022/03/video-pastor-attempts-suicide-in-rivers-state-over-his-church-not-growing-house-rent.html

Moretti, F., van Vliet, L., Bensing, J., Deledda, G., Mazzi, M., Rimondini, M., Zimmermann, C., & Fletcher, I. (2011). A standardized approach to qualitative content analysis of focus group discussions from different countries. *Patient Education and Counseling, 82*, 420-228. https://doi.org/10.1016/j.pec.2011.01.005

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2), 1-22. https://doi.org/10.1177%2F160940690200100202

Morse, J. M., Niehaus, L., Varnhagen, S., Austin, W., & McIntosh, M. (2008). Qualitative researchers' conceptualizations of the risks inherent in qualitative reviews! *International Review of Qualitative Research, 1*(2), 195-215. www.jstor.org/stable/10.1525/irqr.2008.1.2.195

Moustakas, C. (1994). Human science perspectives and models. In Moustakas, C. *Phenomenological research methods* (pp. 1-24). SAGE. https://doi.org/10.4135/9781412995658

Muratori, M., & Haynes, R. H. (2020). *Coping skills for a stressful world: A workbook for counselors and clients* (5th ed.). Wiley.

Namageyo-Funa, A., Rimando, M., Brace, A. M., Richard, R. W., Fowles, T. L., Davis, T. L., Martinez, L. M., & Sealy, D.-A. (2014). Recruitment in qualitative public health research: Lessons learned during dissertation sample recruitment. *The Qualitative Report, 19*(1), 1-17. http://www.nova.edu/ssss/QR/QR19/namageyo-funa1.pdf

National Alliance on Mental Health. (2019). *Mental health by the numbers*. https://www.nami.org/mhstats

National Institute of Mental Health. (2019). *5 things you should know about stress* (NIH Publication No. 19-MH-8109). U.S. Department of Health and Human Services, National Institute of Mental Health. https://infocenter.nimh.nih.gov/nimh/product/5-Things-You-Should-Know-About-Stress/19-MH-8109

National Research Council. (2014). *Proposed revisions to the common rule for the protection of human subjects in the behavioral and social sciences*. Committee on Revisions to the Common Rule for the Protection of Human Subjects in Research in the Behavioral and Social Sciences. Board on Behavioral, Cognitive, and Sensory Sciences, Committee on National Statistics, Division of Behavioral and Social Sciences and Education. The National Academies Press. https://www.ncbi.nlm.nih.gov/books /NBK217980/pdf/Bookshelf_NBK217980.pdf

NBC2.com. (2019, February 20). *Officer commits suicide while under investigation for child porn.* https://www.nbc-2.com/story/39997594/officer-commits-suicide-while-under-investigation-for-child-porn

Nee, W. (1977). *The normal Christian life*. Tyndale House Publishers. (Original work published 1957).

Nestler, E. J., Pena, C. J., Kundakovic, M., Mitchell, A., & Akbarian, S. (2015). Epigenetic basis of mental illness. *The Neuroscientist, 22*(5), 447-463.

Newell, J. M., & Nelson-Gardell, D. N. (2014). A competency-based approach to teaching professional self-care: An ethical consideration for social work educators. *Journal of Social Work Education, 50*(3), 427-438. https://doi:10.1080/10437797.2014.917928

News and Tribune. (2016, June 29). Jeffersonville pastor's death was an apparent suicide. *News and Tribune*. https://www.newsandtribune.com/news/jeffersonville-pastor-s-death-was-an-apparent-suicide/article_eeb9d1b4-3e19-11e6-8ac2-b792db3ab858.html

Nieuwhof, C. (n.d.). *How pastoral care stunts the growth of most churches*. Carey Nieuwhof. https://careynieuwhof.com/how-pastoral-care-stunts-the-growth-of-most-churches/#comments

Noel, D., & Due, K. (2018). Courage and comfort for pastors in need. *Lutheran Theological Journal, 52*(3), 128-140.

Novelly, T. (2017, December 13). Rep. Dan Johnson kills himself days after being accused of sexual abuse. *Courier Journal*. https://www.courier-journal.com/story/news/2017/12/13/rep-dan-johnson-dead/950666001/

Nonnemaker, J. M., McNeely, C. A., & Blum, R. W. (2003). Public and private domains of religiosity and adolescent health risk behaviors: Evidence from the national longitudinal study of adolescent health. *Social Science & Medicine, 57*, 2049-2054. https://doi.org/10.1016/S0277-9536(03)00096-0

Nouwen, H. J. (1979). *The wounded healer: Ministry in contemporary society*. Image Books Doubleday.

Office for Human Research Protections. (2018). *Basic HHS policy for protection of human subjects* (e-CFR Title 45- Subpart A-Part 46). U.S. Department of Health & Human Services (HHS). https://www.hhs.gov/ohrp/regulations-and-policy/guidance/faq/informed-consent/index.html

Okonkwo, O. (2015, May 28). Married pastor commits suicide after confessing to an affair with a church member. *Pulse*. https://www.pulse.ng/communities/religion/in-america-married-pastor-commits-suicide-after-confessing-to-an-affair-with-a-church/ehpyl8n

Olafusi, E. (2020, January 6). A Kenyan pastor, on Sunday stabbed his wife to death and then slit his own throat in front of the congregation. *The Cable*. https://www.thecable.ng/kenyan-pastor-commits-suicide-after-stabbing-wife-to-death-during-service

O'Neal, J. (2022, October 19). *Columbus pastor commits suicide during rape trial recess*. WTVM. https://www.wtvm.com/2022/10/19/columbus-pastor-commits-suicide-during-rape-trial-recess/

Or, S. E. B., Hasson-Ohayon, I., Feingold, D., Vahab, K., Amiaz, R., Weiser, M., & Lysaker, P. H. (2013). Meaning in life, insight, and self-stigma among people with severe mental illness. *Comprehensive Psychiatry, 54*, 195-200. http://dx.doi.org/10.1016/j.comppsych.2012.07.011

Ormerod, N., & Ormerod, T. (2018). *When ministers sin: Sexual abuse in the churches*. Wipf and Stock Publishers.

Oxhandler, H. K., Narendorf, S. C., & Moffatt, K. M. (2018). Religion and spirituality among young adults with severe mental illness. *Spirituality in Clinical Practice, 5*(3), 188-200. https://doi.org/10.1037/scp0000164

Pannucci, C. J., & Wilkins, E. G. (2010). Identifying and avoiding bias in research. *Plastic Reconstructive Surgery, 126*(2), 619-625. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2917255/pdf/nihms-198809.pdf

Parament, K. I., & Lomax, J. W. (2013). Understanding and addressing religion among people with mental illness. *World Psychiatry, 12*(1), 26-32. https://doi.org/10.1002/wps.20005

Parameshwaran, R. (2015). Theory and practice of chaplain's spiritual care process: A psychiatrist's experiences of chaplaincy and conceptualizing trans-personal model of mindfulness. *Indian Journal of Psychiatry, 57*(1), 21-20.

Parcesepe, A. M., & Cabassa, L. J. (2013). Public stigma of mental illness in the United States: A systematic literature review. *Administration and Policy in Mental Health and Mental Health Services Research, 40*, 384-399. https://doi.org/10.1007/s10488-012-0430-z

Parekh, R. (2018). *What is mental illness?* American Psychiatric Association. https://www.psychiatry.org/patients-families/what-is-mental-illness

Payne, J. S. (2013). The influence of secular and theological education on pastors' depression intervention decisions. *Journal of Religion and Health, 53*, 1398-1413. https://doi.org/10.1007/s10943-013-9756-4

Pereira, J. A., Barkham, M., Kellett, S., & Saxon, D. (2017). The role of practitioner resilience and mindfulness in effective practice: A practice-based feasibility study. *Administration and Policy in Mental Health Services Research, 44*, 691-704.

Peteet, J. R. (2019). Approaching religiously reinforced mental health stigma: A conceptual framework. *Psychiatric Services, 70*, 846-848. https://doi.org/10.1176/appi.ps.201900005

Peterson, B. (2019, April 13). Does Galatians 5:19-21 forbid the use of medicine? *Christian Research Journal, 42*(1). https://www.equip.org/article/does-galatians-5-19-21-forbid-the-use-of-medicine/

Petty, N. J., Thomson, O. P., & Stew, G. (2012). Ready for a paradigm shift? Part 2: Introducing qualitative research methodologies and methods. *Manual Therapy*, 378-384. https://doi.org/10.1016/j.math.2012.03.004

Picco, L., Chang, S., Abdin, E., Chua, B. Y., Yuan, Q., Vaingankar, J. A., Ong, S., Yow, K. L., Chua, H. C., Chong, S. A., & Subramaniam, M. (2019). Associative stigma among mental health professionals in Singapore: A cross-sectional study. *BMJ Open, 9*, 1-12.

Pietsch, S. (2011). Luther comforts a depressed pastor: Luther's letter of consolation to George Spalatin-analysis and reflection. *Lutheran Theological Journal, 45*(3), 144-155.

Pink, A. W. (2011). *The divine inspiration of the Bible*. (Original work published 1917). https://ccel.org/ccel/p/pink/inspiration/cache/inspiration.pdf

Plante, T. G. (Ed.). (2013). *Abnormal psychology across the ages: Abnormal psychology across the ages*. ABC-CLIO.

Plotkin, D. (2019, October 28). Orlando pastor and radio host facing child sex abuse charges dies by apparent suicide. *Orlando Weekly*. https://www.orlandoweekly.com/Blogs/archives /2019/10/28/orlando-pastor-and-radio-host-facing-child-sex-abuse-charges-dies-by-apparent-suicide

Pointer, G. R. (2015). *Mentoring men in addiction recovery: The Abyssinian Baptist church (ABC) countering substance abuse in North Philadelphia* [Doctoral Dissertation, Palmer Theological Seminary]. ProQuest Dissertations and Theses Global.

Proeschold-Bell, R. J., & Byassee, J. (2018). *Faithful and fractured: responding to the clergy health crisis*. Baker Academic.

Proeschold-Bell, R. J., LeGrand, S., James, J., Wallace, A., Adams, C., & Toole, D. (2009). A theoretical model of the holistic health of United Methodist clergy. *Journal of Religion Health, 50*, 700-720. https://doi.org/10.1007/s10943-009-9250-1

Proeschold-Bell, R. J., Miles, A., Toth, M., Adams, C., Smith, B. W., & Toole, D. (2013). Using effort-reward imbalance theory to understanding high rates of depression and anxiety among clergy. *Journal of Primary Prevention, 34*(6), 439-453.

QSR International. (n.d.). *NVivo*. https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/about/nvivo

Rahimipour, M., Shahgholian, N., & Yazdani, M. (2015). Effect of hope therapy on depression, anxiety, and stress on the patients undergoing hemodialysis. *Iranian Journal of Nursing and Midwifery Research, 20*(6), 694-699.

Rainer, T. S. (2013, July 6). *How many hours does a pastor work each week?* Church Answers. https://churchanswers.com/blog/how-many-hours-does-a-pastor-work-each-week/

Rainer, T. S. (2014, February 26). *Pastors and mental health.* Church Answers. https://thomrainer.com/2014/02/pastors-and-mental-health/

Rainey, J. (2018). *3 dangers in rejecting mental health care*. Facts and Trends.net. https://factsandtrends.net/2018/09/11/3-dangers-in-rejecting-mental-health-care/

RAND Corporation. (n.d.). *Mental health inventory survey*. https://www.rand.org/health-care/surveys_tools/mos/mental-health.html

Rayburn, C. (2015). Ecclesiastical policies versus lived social relationships: Gender parity, attitudes, and ethics. In Johnson A. (Ed.), *Religion and men's violence against women*. Springer. https://link-springer-com.ezproxy.liberty.edu/chapter/10.1007%2F978-1-4939-2266-6_3

Real Life Church. (n.d.). [photo of pastor Jim Howard]. https://www.reallifechurch.org/mourning-jim-howard/

Reinert, M., Nguyen, T., & Fritze, D. (2020). *The state of mental health in America 2020*. Mental Health America. https://www.mhanational.org/sites/default/files/State%20of%20Mental%20Health%20in%20America%20-%202020.pdf

Religion News Service. (2014, January 23). Isaac Hunter dead: Summit church pastor and son of Obama adviser Joel Hunter dies in apparent suicide. *HuffPost*. https://www.huffpost.com/entry/isaac-hunter-dead_n_4427371

Research philosophy and assumptions-SOBT. (n.d.). https://campustools.capella.edu/BBCourse_Production/PhD_Colloquia/Track_2/SOBT/phd_t2_sobt_u03s1_h01_assumptn.html#:~:text=Ontological%20assumptions%20about%20the%20nature,are%20allowable%20within%20the%20paradigm

Reverend Dale R. Cross Sr. obituary. (n.d.). *Cook Funeral & Cremation Services*. https://www.cookcares.com/obituaries/Dale-Cross/#!/Obituary

Richards, H. M., & Schwartz, L. J. (2002). Ethics of qualitative research: Are there special issues for health services research? *Family Practice, 18*(2), 135-139.

Rickwood, D., & Thomas, K. (2012). Conceptual measurement framework for help-seeking for mental health problems. *Psychology Research and Behavior Management, 5*, 173-183.

Riollano, V. (2019, September 11). Suicide in the church. *I Believe*. https://www.ibelieve.com/health-beauty/suicide-in-the-church.html

Robson, C. (2011). *Real world research* (3rd ed). Wiley

Roelen, C. A. M., Van Hoffen, M. F. A., Waage, S., Schaufeli, W. B., Twisk, J. W. R., Bjorvatn, B., Moen, B. E., & Pallesen, S. (2018). Psychosocial work environment and mental health-related long-term sickness absence among nurses. *International Archives of Occupational and Environmental Health, 91*, 195-203. https://doi.org/10.1007/s00420-017-1268-1

Roepke, A. M., & Seligman, M. E. P. (2015). Depression and prospection. *British Journal of Clinical Psychology, 55*, 23-48.

Ross, H. E., & Stanford, M. S. (2014). Training and education of North American Master's Divinity students in relation to serious mental illness. *Journal of Research on Christian Education, 23*(2), 176-186. https://doi.org/10.1080/10656219.2014.899480

Rosofsky, I. (2009, March 29). Suicide as mastery and control. *Psychology Today*. https://www.psychologytoday.com/us/blog/adventures-in-old-age/200903/suicide-mastery-and-control

Ross, L. E., Vigod, S., Wishart, J., Waese, M., Spence, J. D., Oliver, J., Chambers, J., Anderson, S., & Shields, R. (2015). Barriers and facilitators to primary care for people with mental health and/or substance use issues: A qualitative study. *Family Practice, 16*(135), 1-13. https://doi.org/10.1186/s12875-015-0353-3

Ross, W. (2006). *What is irrational?* REBT Network. http://www.rebtnetwork.org/library/ideas.html

Ruehs, J. B. (2022). *"Who you gonna call?": A missiological evaluation regarding the beliefs and practices of pastors in the Lutheran church-Missouri synod in response to paranormal phenomena within a North American context* (Order. 28966067) [Doctoral dissertation, Columbia International University]. ProQuest Dissertations and Theses Global

Ruffing, E. G., Paine, D. R., Devor, N. G., & Sandage, S. J. (2018). Humility and narcissism in clergy: A relational spirituality framework. *Pastoral Psychology, 67*, 525-545. https://doi.org/10.1007/s11089-018-0830-4

Ruta, L. (2014, March 25). Ex-O.C. youth pastor accused of molestation commits suicide. *The Orange County Register*. https://www.ocregister.com/2014/03/25/ex-oc-youth-pastor-accused-of-molestation-commits-suicide/

Ryle, J. C. (2017). *Holiness*. First Rate Publishers. (Original work published 1877)

Sadeghi, H., Ebrahimi, L., & Vatandoust, L. (2015). Effectiveness of hope therapy protocol on depression and hope in amphetamine users. *International Journal of High-Risk Behaviors and Addiction, 4*(4).

Sager, K. (2019). *An examination of the roles of distress, self-stigma, caregiver role identity, and self-compassion in clergy help-seeking attitudes* [Doctoral dissertation, University of Kansas]. https://kuscholarworks.ku.edu/handle/1808/31544

Salazar, M. K. (1990). Interviewer bias: How it affects survey research. *AAOH Journal, 38*(12), 567-572. https://journals.sagepub.com/doi/pdf/10.1177/216507999003801203

Salwen, E. D., Underwood, L. A., Dy-Liacco, G. S., & Arveson, K. R. (2017). Self-disclosure and spiritual well-being in pastors seeking professional psychological help. *Pastoral Psychology, 66*, 505-521. https://doi.org/10.1007/s11089-017-0757-1

Sanders, O. J. (2017). *Spiritual leadership: principles of excellence for every believer*. Moody Publishers.

Santos, A. M. S., & Novo, R. E. (2020). Mental health inventory: Sensitivity and specificity of the Portuguese version of the MHI-38 and MHI-5. *Psychological Reports, 123*(4), 1452-1469. https://doi.org/10.1177/0033294119850490

Sasso, K. E. (2012). *Prediction of therapeutic process and outcome: Examining observer ratings of client characteristics* [Honors research thesis]. Ohio State University. https://pdfs.semanticscholar.org/135b/e6469de95ee5dedf1c2b864ba53dd136de13.pdf

Saunders, B., Sim, J., Kingston, T., Baker, S., Waterfield, J., Barlam, H., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality & Quantity, 52*, 1893-1907. https://doi.org/10.1007/s11135-017-0574-8

Savage, H., Murray, J., Hatch, S. L., Hotopf, M., Evans-Lacko, S., & Brown, J. S. L. (2016). Exploring professions help-seeking for mental disorders. *Qualitative Health Research, 26*(12), 1662-1673.

Schnell, L. (2019, September 14). Suicide of prominent pastor Jarrid Wilson forces church leaders to confront mental health. *USA Today*. https://www.usatoday.com/story/news/nation/2019/09/14/jarrid-wilsons-suicide-forces-churches-confront-mental-health/2313458001/

Schomerus, G., Schwahn, C., Holzinger, A., Corrigan, P. W., Grabe, H. J., Carta, M. G., & Angermeyer, M. C. (2012). Evolution of public attitudes about mental illness: A systematic review and meta-analysis. *Acta Pscyhiatrica Scandinavica, 125*, 440-452.

Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. *International Review of Psychiatry, 19*(2), 137-155.

Schummer, J. R. (2019). *Safe coping skills*. Independently published. https://www.amazon.com/Safe-Coping-Skills-Justina-Schummer/dp/1072401894

Scott, G., & Lovell, R. (2015). The rural pastor's initiative: Addressing isolation and burnout in rural ministry. *Pastoral Psychology, 64*, 71-97. https://doi.org/10.1007/s11089-013-0591-z

Scott, J. (2021, June 18). *Pastors in crisis: Reasons why so many ministers are considering quitting vocational ministry.* Church Leaders. https://churchleaders.com/pastors/pastor-articles/399595-pastors-in-crisis-reasons-why-so-many-ministers-are-considering-quitting-vocational-ministry.html

Scott, R. P., & Bergin, A. E. (Eds.). (2014). *Handbook of psychotherapy and religious diversity* (2nd ed.). American Psychological Association. https://psycnet-apa-org.ezproxy.liberty.edu/doi/10.1037/14371-000

Segall, L. (2015, September 8). *Pastor outed on Ashley Madison commits suicide.* CNN Business. https://money.cnn.com/2015/09/08/technology/ashley-madison-suicide/

Seligman, L., & Reichenberg, L. (2014). *Theories of counseling and psychotherapy systems, strategies, and skills* (4th ed.). Pearson.

Shaw, S. M. (2019, June 27). *Should Southern Baptist women be preachers? A centuries-old controversy finds new life.* The Conversation.com. https://theconversation.com/should-southern-baptist-women-be-preachers-a-centuries-old-controversy-finds-new-life-118671

Shearer, M. (2015, May 26). Pastor's suicide leaves community grieving. *Newark Advocate*. https://www.newarkadvocate.com/story/news/local/2015/05/26/pastors-suicide-leaves-community-grieving/27981057/

Silver, M. (2006). *A plausible God*. Fordham University Press.

Simmons, J., Wijma, B., & Swahnberg, K. (2015). Lifetime co-occurrence of violence victimization and symptoms of psychological ill health: A cross-sectional study of Swedish male and female clinical and population samples. *BMC Public Health, 15*(979), 1-14. https://doi.org/10.1186/s12889-015-2311-3

Simon, R. I. (2014). Passive suicidal ideation: Still a high-risk clinical scenario. *Current Psychiatry, 13*(3), 13-15. https://mdedge-files-live.s3.us-east-2.amazonaws.com/files/s3fs-public/Document/September-2017/013_0314CP_Commentary_FINAL.pdf

Skovholt, T. M., & Trotter-Mathison, M. (2016). *The resilient practitioner: Burnout and compassion fatigue prevention and self-strategies for the helping professions*. Taylor & Francis Group.

Smietana, B. (2013, September 2013). *Mental health: Half of evangelicals believe prayer can heal mental illness.* Lifeway Research Group. https://lifewayresearch.com/2013/09/17/mental-health-half-of-evangelicals-believe-prayer-can-heal-mental-illness/

Smietana, B. (2014, September 22). *Mental illness remains taboo topic for many pastors*. Lifeway Research Group. https://lifewayresearch.com/2014/09/22/mental-illness-remains-taboo-topic-for-many-pastors/

Smietana, B. (2020, May 9). Fund set up to benefit family of Darrin Patrick. *Religious News Service*. https://religionnews.com/2020/05/09/fund-set-up-to-benefit-family-of-darrin-patrick/

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis, theory, method, research*. SAGE.

Smith, J. A., & Nizza, I. E. (2022). *Essentials of interpretative phenomenological analysis*. American Psychological Association

Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 53-80). SAGE.

Smith, J. A., & Shinebourne, P. (2012). Interpretative phenomenological analysis. In H. Cooper, P. M., Camic, D.L. Long, A. T., Panter, D., Rindskopf, & K. J., Sher (Eds.), *APA handbooks in psychology*. *APA Handbook of research methods in psychology, Vol. 2*. *Research designs: Quantitative, qualitative, neuropsychological, and biological* (p. 73-82). American Psychological Association. https://doi.org/10.1037/13620-005

Smith, K. (2020, January 16). I was a pastor struggling with depression. The evangelical community offered virtually no helpful resources. *Baptist News Global*. https://baptistnews.com/article/i-was-a-pastor-struggling-with-depression-the-evangelical-community-offered-virtually-no-helpful-resources/#.XxIJmihKgdU

Smith, L. (2019, May 3). Cedar Hill pastor shot himself as house burned with wife, teen daughters inside. *The Dallas Morning News*. https://www.dallasnews.com/news /2019/05/03/cedar-hill-pastor-shot-himself-as-house-burned-with-wife-teen-daughters-inside/

Smith, S. (2015, September 9). "Beloved" pastor and seminary professor commits suicide after being exposed in Ashley Madison hack. *The Christian Post*. https://www.christianpost.com/news/beloved-pastor-and-seminary-professor-commits-suicide-after-being-exposed-in-ashley-madison-hack.html

Snelgar, R. J., Renard, M., & Shelton, S. (2017). Preventing compassion fatigue amongst pastors: The influence of spiritual intelligence and intrinsic motivation. *Journal of Psychology & Theology, 45*(4), 247-260.

Spencer, J. L., Winston, B., & Bocarnea, M. (2012). Predicting the level of pastors' risk of termination/exit from the church. *Pastoral Psychology, 61*, 85-89.

Spillman, B. D. (2006). *Men's experiences of depression: A phenomenological investigation* (UMI No. 3235516) [Doctoral dissertation, University of Tennessee]. ProQuest Dissertations and Theses Global.

Spurgeon, C. H. (2019). *The blood of the lamb, the conquering weapon* [Sermon]. The Metropolitan Tabernacle, Newington. (Original work published September 9th, 1888). https://ccel.org/ccel/spurgeon/sermons34 /sermons34.xli.html?queryID=4025855&resultID=178875

St. Irenaeus. (1920). *The proof of the apostolic preaching*. http://www.tertullian.org/fathers/irenaeus_02_proof.htm (Original work published ca. 200-201 B.C.E.)

Stanford, M. S. (2007). Demon or disorder: A survey of attitudes toward mental illness in the Christian church. *Mental Health, Religion & Culture, 10*(5), 445-449. https://doi.org/10.1080/13674670600903049

Starnino, V., & Sullivan, P. W. (2017). Early trauma and serious mental illness: What role does spirituality play? *Mental Health, Religion & Culture, 19*(10), 1094-1117. https://doi.org/10.1080/13674676.2017.1320368

Stetzer, E. (2018a, April 20). The church and mental health: What do the numbers tell us? *Christianity Today*. https://www.christianitytoday.com/edstetzer/2018/april/church-and-mental-health.html

Stetzer, E. (2018b, January 22). List of pastors' retreats and getaways. *Christianity Today*. https://www.christianitytoday.com/edstetzer/2014/march/free-or-discounted-getaways-for-pastors.html

Strong, R. (2017). *Pastoral burnout of African American pastors: A biblical and practical solutio*n [Unpublished doctoral dissertations, Liberty University]. https://core.ac.uk/download/pdf/83112365.pdf

Sullivan, D. (2014, May 16). Pastor at West Tampa church commits suicide amid financial inquiry. *Tampa Bay Times*. https://www.tampabay.com/news/obituaries/pastor-at-west-tampa-church-commits-suicide-amid-financial-inquiry/2180202/

Sullivan, S., Pyne, J. M., Cheney, A. M., Hunt, J., Haynes, T. F., & Sullivan, G. (2014). The pew versus the couch: Relationship between mental health and faith communities and lessons learned from a VA/Clergy partnership project. *Journal of Religion and Health, 53*(4), 1267-1282. https://doi.org/10.1007/s10943-013-9731-0

Sutton, J., & Austin, Z. (2015). Qualitative research: Data collection, analysis, and management. *The Canadian Journal of Hospital Pharmacy, 68*(3), 226-231. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4485510/

Tao, J. (2019a, September 6). New testimonies help to sort out the mystery of pastor's suicide. *Bitter Winter*. https://bitterwinter.org/new-testimonies-help-to-sort-out-the-mystery-of-pastors-suicide/

Tao, J. (2019b, September 6). [Song Yongsheng photo]. *Bitter Winter*. https://bitterwinter.org/new-testimonies-help-to-sort-out-the-mystery-of-pastors-suicide/

Tap, K. (2019, September 6). New testimonies help to sort out the mystery of pastor's suicide. *Bitter Winter*. https://bitterwinter.org/new-testimonies-help-to-sort-out-the-mystery-of-pastors-suicide/

Teodoro, R. R. (2020, June 10). [Missionary of the assembly of God is thrown from the bridge photo]. *Gazetamt online Portuguese newspaper*. https://translate.google.com/translate?hl=en&sl=pt&u=https://gazetamt.net/2020/06/10/missionaria-da-assembleia-de-deus-se-joga-da-ponte-e-tudo-e-filmado-ela-lutava-contra-uma-depressao-profunda/&prev=search&pto=aue

Terry, J. D., & Cunningham, C. J. L. (2019). The sacred and stressed: Testing a model of clergy health. *Journal of Religion and Health, 59*(3), 1541-1566.

The Herald. (2021, October 26). Pastor under investigation found dead at mercer motel. *The Herald*. https://www.sharonherald.com/gallery/pastor-under-investigation-found-dead-at-mercer-motel/article_ce07fc0a-1d3c-5a1f-89a0-263314f4b49c.html

Thirioux, B., Birault, F., & Jaafari, N. (2016). Burnout in physicians: New neuro-phenomenological hypotheses regarding empathy and sympathy in care relationship. *Frontiers in Psychology, 7*. https://doi.org/10.3389/fpsyg.2016.00763

Thomas, D. W. H. (2018). *The Bible: God's inerrant word*. Banner of Truth.

Thornicroft, G., Brohan, E., Rose, D., Sartorius, N., & Leese, M. (2009). Global pattern of experienced and anticipated discrimination against people with schizophrenia: A cross-sectional survey. *The Lancet, 373*(9961), 408-415. https://doi.org/10.1016/S0140-6736(08)61817-6

Thorsen, S. V., Rugulies, R., Hjarsbech, P. U., & Bjorner, J. B. (2013). The predictive value of mental health for long-term sickness absence: The Major Depression Inventory (MDI) and the Mental Health Inventory (MHI-5) compared. *BMC Medical Research Methodology, 13*(115), 1-7. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3848657/

Times of India. (2019, October 23). Chennai: Pastor found hanging on church premises. https://timesofindia.indiatimes.com/city/chennai/pastor-found-hanging-on-church-premises/articleshow/71712356.cms

Timmons, S. M. (2009). Pastor's influence on research-based health programs in church settings. *Journal of Health Disparities Research and Practice, 3*(2), 92-102.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19*(6), 349-357. https://academic.oup.com/intqhc/article/19/6/349/1791966

Torkzadeh, F., Danesh, M., Mirbagher, L., Daghaghzadeh, H., & Emami, M. H. (2019). Relations between coping skills, symptom severity, psychological symptoms, and quality of life with irritable bowel syndrome. *International Journal of Preventive Medicine, 10*(1), 1-6.

Tracy, T. (2017). Dead man found in Bronx Bay identified as pastor who likely killed himself. *Daily News*. https://www.nydailynews.com/new-york/man-found-nyc-bay-identified-pastor-killed-article-1.3327974

Tunnell, J. (2020). *Pastoral burnout: Practical and biblical insights for prevention and rehabilitation within the International Pentecostal Holiness church.* Doctoral Dissertations and Projects. https://digitalcommons.liberty.edu/doctoral/2603

Umubyeyi, A., Mogren, I., Ntaganira, J., & Krantz, G. (2015). Help-seeking behaviours, barriers to care and self-efficacy for seeking mental health care: a population-based study in Rwanda. *Social Psychiatry and Psychiatric Epidemiology, 51*, 81-92. https://doi.org/10.1007/s00127-015-1130-2

University of California. (n.d.). *Assessing risks and benefits*. UCI Office of Research. https://research.uci.edu/compliance/human-research-protections/irb-members/assessing-risks-and-benefits.html

Unsworth, T. (1993). Clergy suicides tip of depression iceberg: Clergy mental health long neglected. *National Catholic Report, 29*(42), 1-4. https://link.gale.com/apps/doc/A14219091/BIC?u=vic_liberty&sid=summon&xid=845838eb

Unterrainer, H. F., Lewis, A. J., & Fink, A. (2014). Religious/spiritual well-being, personality, and mental health: A review of results and conceptual issues. *Journal of Religion and Health, 53*, 382-392. https://doi.org/10.1007/s10943-012-9642-5

Vacek, H. H. (2015). *Madness: American Protestant responses to mental illness*. Baylor University Press.

Valach, L., Michel, J., & Young, R. (2016). Suicide as a distorted goal-directed process: Wanting to die, killing, and being killed. *The Journal of Nervous and Mental Disease, 204*(11), 812-819. https://doi.org/10.1097/NMD.0000000000000528

Van de Velde, S., Van der Bracht, K., & Buffel, V. (2017). The relation between religion and depression in Europe: The moderating role of the religious context. *International Journal of Comparative Sociology, 58*(6), 515-532. https://doi.org/10.1177/0020715217736361

Van Der Kolk, B. (2014). *The body keeps score: Brain, mind, and body in the healing of trauma*. Penguin Random House.

van Dijk, I., Lucassen, P. L. B. J., van Weel, C., & Speckens, A. E. (2017). A cross-sectional examination of psychological distress, positive mental health, and their predictors in medical students in their clinical clerkships. *BMC Medical Education, 17*(219), 1-11

Van Hoogendoorn, W., Poppel, M. N. N., Bongers, P. M., Koes, B. W., & Bouter, L. M. (2000). Systematic review of psychosocial factors at work and private life as risk factors for back pain. *SPINE, 25*(16), 2114-2125

Van Orden, K. A., Begley, A. E., Conwell, Y., & Reynolds, C. F. (2014). Does reducing social disconnectedness represent a mechanism whereby depression treatment reduces suicide risk? *American Journal of Geriatric Psychiatry, 22*(3), S134-S135. https://doi.org/10.1016/j.jagp.2013.12.157

Van Wijk, E., & Harrison, T. (2013). Managing ethical problems in qualitative research involving vulnerable populations, using a pilot study. *International Journal of Qualitative Methods, 12*(1), 570-586. https://doi.org/10.1177/160940691301200130

VanderWaal, C. J., Hernandez, E. L., & Sandman, A. R. (2012). The gatekeepers: Clergy involvement in referrals and collaboration with mental health and substance abuse professionals. *Social Work & Christianity, 39*(1), 27-51. http://digitalcommons.andrews.edu/socialwork-pubs/5

Varshney, M., Mahapatra, A., Krishnan, V., Gupta, R., & Deb, K. S. (2016). Violence and mental illness: What is the true story? *Journal of Epidemiology and Community Health, 70*(3), 223-225.

Vaughan, G., & Hansen, C. (2004). “Like minds, like mine”: A New Zealand project to counter the stigma and discrimination associated with mental illness. *Australasian Psychiatry, 12*(2), 113-117.

VERBI Software. (2022). *MAXQDA 2022 manual*. https://www.maxqda.com/help-mx22/welcome

Vicary, S., Young, A., & Hicks, H. (2017). A reflective journal as learning process and contribution to quality and validity in interpretative phenomenological analysis. *Qualitative Social Work, 16*(4), 550-565. https://doi.org/10.1177%2F1473325016635244

Victorinus. (2020). Victorinus of Pettau. In *Ante-Nicene Fathers, Volume 7* (Roberts, D. D., & Donaldson, J., Trans.). http://www.earlychristianwritings.com/victorinus.html (Original work published ca. 270-310 C.H.E./1885)

Vilhauer, R. P. (2017). Stigma and need for care in individuals who hear voices. *International Journal of Social Psychiatry, 63*(1), 5-13.

Virzi, J. (2019, January 29). *Real-life church pastor Jim Howard dies by suicide*. The Mighty. https://themighty.com/2019/01/jim-howard-real-life-church-suicide/

Visker, J. D., Rider, T., & Humphers-Ginther, A. (2016). Ministry-related burnout and stress coping mechanisms among assemblies of God-ordained clergy in Minnesota. *Journal of Religion and Health, 56*(3), 951-961.

Vohs, K. D., & Baumeister, R. F. (2016). *Handbook of self-regulation: Research, theory, and applications* (3rd ed.). Guilford Publications.

Wahl, O. F. (1999). Mental health consumers' experience of stigma. *Schizophrenia Bulletin, 25*(3), 467-478.

Wainwright, S. R., & Galae, L. A. M. (2013). The neural plasticity theory of depression: Assessing the role of adult neurogenesis and PSA-Ncam within the hippocampus. *Neural Plasticity*. http://dx.doi.org/10.1155/2013/805497

Walker, W. (2007). Ethical considerations in phenomenological research. *Nurse Researcher, 14*(3), 36-45. https://pdfs.semanticscholar.org/1ae7/84996ed16d53311e995b7d2fe905a4121ea8.pdf

Walther, N. G., Proeschold-Bell, R. J., Benjamin-Neelon, S., Adipo, S., & Kamaara, E. (2015). "We hide under the scriptures": Conceptualization of health among United Methodist church clergy in Kenya. *Journal of Religious Health, 54*, 2235-2248. https://link.springer.com/article/10.1007/s10943-014-9947-7#citeas

Warner, G. (2009, December 1). When depression leads pastors to suicide. *The Christian Century, 126*(24), 14.

Watkins, D. C., & Neighbors, H. W. (2007). An initial exploration of what "mental health" means to young black men. *The Journal of Men's Health and Gender, 4*(3), 271-282. https://doi.org/10.1016/j.jmhg.2007.06.006

Watson, T. (2018). *The great gain of godliness*. Versa Press Inc. (Original work published 1682)

Weaver, A. J. (1995). Has there been a failure to prepare and support parish-based clergy in their role as frontline community mental health: A review. *The Journal of Pastoral Care, 49*(2), 129-147.

Wells, C. R. (2013). The moderating effects of congregational and denominational support on the impact of stress on clerical emotional and physical health status. *Pastoral Psychology, 62*, 873-888. https://doi.org/10.1007/s11089-013-9522-z

Weng, S. (2013, November 13). Pastor Teddy Parker commits suicide as congregation waits for him after confessing sometimes, he "can't feel God." *Christian Today*. https://www.christiantoday.com/article/pastor.teddy.parker.commits.suicide.congregation.waits.for.him.after.confessing.sometimes.he.cant.feel.god/34672.htm

Whitfield, N., & Kanter, D. (2014). Helpers in distress: Preventing secondary trauma. *Reclaiming Children and Youth, 22*(4), 59-61).

Whitson, R. P. (2014). *Occupational hazards: Navigating six challenges that can harm pastors and shorten their tenure* (Order No. 361744) [Doctoral dissertation, Talbot School of Theology]. ProQuest Dissertations and Theses Global.

WHO Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*: *Final report on the Commission on Social Determinants of Health.* World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf;jsessionid=A122D526EFD07B776359DA3DDCC9E2C6?sequence=1

Wickman, C. A. (2014). *Pastors at risk: Protecting your future guarding your present*. Morgan James Publishing.

Wilkes, M. (2019, September 18). "Let's talk": Georgia pastor shares his own story of depression. *The Christian Index*. https://christianindex.org/wilkes-depression-lets-talk/

Wilkowska, A., Rynkiewicz, A., Wdowczyk, J., & Landowski, J. (2019). Morning and afternoon serum cortisol level in patients with post-myocardial infarction depression. *Cardiology Journal, 26*(5), 550-554.

Williams, A. E. (2014). The safety of researchers and participants in primary care qualitative research. *British Journal of General Practice, 64*(621), 198-200. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3964461/#!po=95.4545

Williams, R. N., & Faulconer, J. E. (1994). Religion and mental health: A hermeneutic reconsideration. *Review of Religious Research, 35*(4), 335-349. http://www.jstor.org/stable/3511734

Wilson, N. (2011). *A quantitative research study analyzing responses or reactions of personal and professional stress-related factors that can lead to ministry stress or burnout in Chinese pastors* [Doctoral dissertation, University of the Rockies]. ProQuest Dissertation and Theses Global.

Wong, E. C., Fulton, B. R., & Derose, K. P. (2018). Prevalence and predictors of mental health programming among U.S. religious congregations. *Psychiatric Services, 69*(2), 154-160

World Health Organization. (n.d.). *WHOQOL: Measuring quality of life*. https://www.who.int/healthinfo/survey/whoqol-qualityoflife/en/

Worthington, E. L., Berry, J. T. D., Hook, J. N., Davis, D. E., Ripley, J. S., & Greer, C. L. (2014). Psychotherapy with mainline protestants: Lutheran, Presbyterian, Episcopal/Anglican, and Methodist. In Richards, P. S., & Bergin, A. E. (Eds.), *Handbook of psychotherapy and religious diversity* (2nd ed., 103-128). http://dx.doi.org/10.1037/14371-005

Xiao, X., Change, H., & Li, M. (2017). Molecular mechanisms underlying noncoding risk variations in psychiatric genetic studies. *Molecular Psychiatry, 22*, 497-511.

Yalden, J. (2019, October 29). *Jarrid Wilson suicide: I'm angry and disappointed*. Jeff Walden Foundation, Inc. https://jeffyalden.com/jarrid-wilson-suicide-im-angry-and-disappointed/#:~:text=In%20September%2C%20Harvest%20Christian%20Fellowship,at%20only%2030%20years%20old.&text=Jarrid%20was%20a%20passionate%20advocate,where%20he%20was%20a%20pastor

Yamazaki, S., Fukuhara, S., & Green, J. (2005). Usefulness of five-item and three-item mental health inventories to screen for depressive symptoms in the general population of Japan. *Health and Quality of Life Outcomes, 3*(48), 1-7. https://doi.org/10.1186/1477-7525-3-48

Zarb-Cousin, A. W. (2019). *Serving those who spiritually serve us: Understanding the lived experiences of clergy members who have accessed and/or received mental health services* (UMI No. 27831094). [Doctoral dissertation, Our Lady of the Lake University]. ProQuest Dissertations and Theses Global.

Zippia.com. (2022, September 9). *Pastor demographics and statistics in the US.* Zippia The Career Expert. https://www.zippia.com/pastor-jobs/demographics/

Zoom. (2020, July). *Security guide*. Zoom Video Communications, Inc. https://zoom.us/docs/doc/Zoom-Security-White-Paper.pdf

Zylstra, S. E. (2016, November 23). *Why pastors are committing suicide*. The Gospel Coalition U.S. Edition. https://www.thegospelcoalition.org/article/why-pastors-are-committing-suicide/

APPENDICES
APPENDIX A
IRB APPROVAL

IRB #: IRB-FY20-21-68
Title: American Church Leader's Responses to Mental Illness
Creation Date: 8-8-2020
End Date:

Status: Approved
Principal Investigator: Erica Harris Review Board: Research Ethics Office
Sponsor:

Study History

Submission Type Initial	Review Type Limited	Decision Exempt - Limited IRB

APPENDIX B

INTERPRETATIVE RESULTS OF INTERVIEWS & QUOTES

SOLOMON	PAGE/LINE	QUOTES
THEME 1: TROUBLED BEGINNING		
Family history of self-harm problematic	6.272-277	*"The self-harm…I probably learned that from my dad…my dad's sister committed suicide…then my dad had talked to me about committing suicide himself…I had to talk him out of it three or four times…I'm sure that that affected my thought process at that point in my life."*
Lack of preparation at the beginning of the ministry problematic	8.358-360	"Yeah, inexperience [and]…*many interactions with church people that aren't roses…aren't the best interactions."*
THEME 2: THE DESCENT INTO DARKNESS		
Suicidal thoughts problematic	4&5.202-204	*"I need to get help…so I immediately called my pastor and said, 'I really need to meet with you, I'm thinking about harming myself and I need some perspective'."*
Negative coping problematic	9.410-427	*"I've experienced depression…it was just a weird, weird time for three years…some anxiety developed, and I felt like I was coping with it, then Covid hit…and we had just gone through a harder season in our church…and then all my coping…went out the window."*
Permanent mental scarring from being betrayed	6.296-299. 289; 262-268 PARA	*"The betrayal part, man…I can't believe that* [after] *I've watched their children and ministered to them so well and this is what I get for it…I felt sad* [and] *thought, 'if this is reality of ministry, I don't want to be in it, because look at the harm I've done to them, but also that they've done to me,' then the sadness turned to anger"* , and, *"I felt confusion…so now I have a wound, every time I plan a retreat* [or] *ask a church member* [to] *use* [their] *things , I get anxious ."*

Church drama problematic	4.175-174. 179-182. 187; 191-195 PARA	"*I had a great relationship with a church member* [and] *we were heavily invested in each other* …we planned…and did everything [together]," but one Sunday after having hosted an event at this member's house, per their request, the participant was confronted by the member, "*Everybody you brought* [are] *welcomed back to our home, but you are never welcome back.*" "I remember feeling so terrible because of the broken relationship…so I consulted my elders" who concluded that being betrayed is a common problem that happens "*in the church so as ministers you have to learn how to handle that.*"
Stigma in the church problematic	12.578-585	"*The counseling center that's located at our church, I've chosen to not use it, and to go outside of it because I feel more comfortable…because…the stigma of just…going up to that counseling area, I know all the counselors, they go to church with me, they would be professional, but I have to be-I don't wanna be cautious about what I say in a counseling session.*"

ABRAHAM	**PAGE/LINE**	**QUOTES**
BEING FULLY PREPARED TO PERFORM THE PASTORAL ROLE		
Pastors are above lay people	5.234	*I think a lot of us are in denial, that we can't be us, we're the preacher.*
Realized lacked insight into his mental health when trying to uphold stable ministry image	5.235	*I can't have mental health issues, I can't have problems, yeah you can.*
Felt exhausted from working multiple jobs while in school and leading the church	2.73-84	*I was single, [battling through] working two jobs, doing pre-marital and marital counseling…in school, dealing with personal issues and the pressures of being a young minister.*
FULLY PREPARED TO PERFORM THE PASTORAL ROLE		
Questioning identity as a pastor	3.134-137	*I'm not good enough,* something must be wrong with me…*I lost my zeal to really preach…I don't need to do this because I can't lead God's people to where God wants them because I'm so messed up.*
Feared exposure of psychiatric issues would lead to job loss	3.104	*Let's be honest, the church I was at, they woulda let me go.*
Felt incompetent performing role	2.49	*I feel like I can't open up to anyone because they will see my flaws and issues.*
Feeling overwhelmed by the external pressures to fit into the preconceived pastor role	4.187-189	*I didn't know how to turn it off and have my time…I think that was a major problem because I was on 24 hours a day seven days a week, umm which isn't a good thing.*
The burden of helping others	1.32	*We consume everyone else's problems and help them work through it, but then we don't have a healthy outlet.*
		MAINTAIN A PASTORAL ROLE WHILE EXPERIENCING PSYCHIATRIC
Resents the carrying of other's problems when no one was willing to help him	4.150-153	
THEME 3: THE STRUGGLE TO		

[I felt] *used by a lot of people cause I felt like I was there to help a lot of people but none of them were there to help me…the same people who were slandering me and talking about me were the same people that I had helped for years.*

		Just the pressures of being a young minister…umm everything so started drinking…drinking wasn't helping becoming sexual immoral, but then doing those things I felt guilty…and I remember one day, I got so drunk that I passed out and when I came to, I had the gun in my hand but the gun had jammed.
Downward progression into unhealthy and sinful behaviors	2.83-89	
Recognized feeling overwhelmed	4.160-161	*I think a lot of times with ministers, we just don't have any type of outlet*
He struggled using position to justify his lack of self-care	2.92-95	*My primary care physician said I was highly depressed and told me to go see a psychiatrist but I'm a full-time minister. Didn't make time to do it.*
Realized could no longer handle things on his own	3.110-111	*When I was contemplating committing suicide, that's when I realized that I needed to go see a psychiatrist.*
Being overworked gets in the way of self-care	4.183-185	*I did literally nothing for self-care…but for everyone, I've ministered to; I took hold of all their problems… I didn't know how to turn it off.*
		Felt alone with hidden pain 4.148-150
Dejected that pastors succumb to the pressures to be perfect	2.47	
CONSEQUENCES OF BEING OVERWORKED		
Experiencing severe feelings of doubts, shame, and guilt	5.193-195	

It's more of a reality [pastors committing suicide]
…because of the stigma of ministers having it all the way together, ummm having no issue, no problems.

I felt too vulnerable…umm, I was ashamed that I allowed myself to get to that point, umm…scared because I didn't think I would ever get out of that state of mind.

I just felt…very lonely…just really felt isolated.

Shocked and dismayed by the lack of support from his congregation	4.146	*I felt a lot of church hurt from a lot of people who had turned on me.*
Blaming self	1.42-43	*I caused some of my own mental illness issues and even mental breakdowns.*
Feeling severe hopelessness	2.52	*I become more mentally unhealthy and because of that, then a lot of the times the only way out that we see is suicide.*
A peer helped save his life	2.124-127	*I happen to just be ya know having a mental breakdown and I was literally about to kill myself and a preacher friend of mine popped up in my apartment…and he talked me off the ledge.*
THEME 5: RECOVERY: CHANGE IN MINDSET AND NEED FOR SUPPORT		
Accepted help from friends & professionals	5.227-232	important to] *find someone you can be accountable to [besides a therapist] I have…other clergies that we talk two or three times a week…we make sure we stay mentally healthy!*
No longer fears being exposed for having had mental illness	5.216-217	*I've had mental health issues and I'm not afraid to talk about those things.*
Recognizes need for a balanced life & more comfortable setting boundaries	5.199-206	*[I] make sure I have my time everyday [no counseling others, no work, or mandatory meetings], 12:00 to 1:30 is my time* [to do whatever he wants]*, it's my time…and I won't budge for anyone or anything*

RACHEL	**PAGE/LINE**	**QUOTES**
PREPARED TO PERFORM THE ROLE OF MINISTER		
She felt disheartened as she did think her training adequately prepared her to manage personal and ministry life	1-2.45-68	"*The expectation is…I'm going to teach, I'm going to lead, I'm going to pray…I'm going to be the one administrating and coordinating and training and I think I was less prepared and didn't anticipate…the* [challenges with] *interpersonal care* [and conflicts when] *…seminary…training all focused on academic teaching…I had one class on pastoral counseling…and zero training on conflict resolution…I was just naïve to how much* [resolving conflicts*] would be a part of my job* ."
Disappointed in the unfair comparison with celebrity pastors	3.133-135	"*The call* " to be a preacher used to be about having biblical knowledge, and being "*a faithful leader and lover of people*," but "*it's so different now"*, it is no longer about the faithful teaching of God's word and care of the people, now it's "*constant comparison ...like are you as good as Beth Moore* ?"
Questions the stereotype of the perfect pastor	3.101-109	"*There's just a lot of levels of toxic expectations that bring pastors to that place (being suicidal) that pastors are supposed to be CEOs and incredible teachers and great pastoral caregivers…the higher in the church hierarchy…the more you feel like you have to take on...and then at some point, something snaps.*"
THE UNEXPECTED CHALLENGES OF BEING A MINISTER		
Started questioning if God had called her to be a minister	2.79-81	"*I shouldn't be in this position…it's more than I expected and if I don't naturally know how to deal with it, then I must not be the right leader.*"

Felt obligated to take on more tasks	5.212-213	"*I was the longest-term staff person…so I started taking on an extra amount of work…so I was overwhelmed.*"
Felt overwhelmed by external pressures	5.229-232	"*Feeling pressured to perform even though I felt like was in a place where I was depleted and yet still being asked of and leaned upon that was just creating a lot of stress.*"
Helplessness prevented her from seeing any solutions	6.263-264	"*What was I thinking to do about* [it]? (About her growing fears and hopelessness triggered by work stress) *Well, I wasn't sure, I felt stuck.*"
Feared being judged negatively by supervisor	6.269-270	"*I didn't wanna be honest with my boss cause I felt that would* [make] *me seem like I'm not a team player…like I'm complaining.*"
Feared being judged as not competent to lead the church because of her gender and mental health issues	7.306-308	"*Is there going to be judgment on me…this* (Being a female with emotional issues) *may be seen as a weakness…a distraction from leadership.* "
NEEDED TO DO TO EFFECTIVELY MANAGE THE ROLE OF BEING A MINISTER		
Overcame her reluctance to share her struggles with her supervisor	6.278-280	"*I started having panic attacks and so that kinda forced my hand and at that point, I was really honest. I went to our lead pastor and was like, "I need to stop working right now.*"
She realized the need to establish realistic boundaries with self and others	8.390-391	"*I think for me not holding onto the anxiety or expectation I've got to do everything and I've gotta be everything to everyone.*"
She realized her way of thinking was not helping her	9.441-446	"*Realizing my perception of failure is not accurate…so what I'm trying to do with my thinking is to shift more toward a growth mentality* [rather than] *a failure mentality.*"
Accepted has to maintain the balance of mental, physical, and spiritual functioning to prevent burnout	9.404-409	"*My first calling is to be communing with God…in His word and in prayer…then see a counselor* …[take] *medication* … [and not] *push against my exhaustion* [instead] I*'m leaning into rest* [ing]."

She values church cultures that support pastors with mental illness	11.502-518	"*I know churches that deny the reality of mental health problems* [but] y*ou need allies, you need partners who get it, who will pray, who will help you, point you to counselors…if you can ignore the naysayers because they're out there in the Christian community.*"

DANIEL THEME 1: EXPECTATIONS OF THE FULLY FUNCTIONING PASTOR	PAGE.LINE	QUOTES
Afraid of being seen as *"weak"*	10. 351-354	"*Since I was 18 years old, I was a United States Marine, we don't-I'm not depr-like I was a drill instructor in the Marines, I don't get depressed…I'm not weak...that's for weak people…non-hackers…depression and anxiety that's a weakness, that's not me!"*
Pride prevents admitting or seeking help	5.155-157	*"[It] is our pride as men, we don't wanna admit that we've failed in some way…and not even a moral failure, just…failing at anything, I'm the leader of the church and I'm not doing it well, I don't want to admit it."*
Fear of being vulnerable is motivator in hiding mental health struggles	6.197	"*We're very guarded…being vulnerable is a scary place for a minister."*
Feared being judged	12.415-416	"*But being able to admit to someone else, to say, "Oh, the reason I was doing this is because I struggle with depression." Then my mind thinks, "that if you think, if you know that I have depression, then you're gonna think…less of me, you're gonna think I'm weak* ."
Feared loss of job if revealed needed help for mental issues	19.724-734	"*When I bottomed out and asked for help from my church leadership…part of the reason ministers can't ask for help is because it's not safe, if they admit that they have a problem then they're gonna be…dropped from the ministry…I would've been fired* ."

Being betrayed by those he trusted was not something he expected	4.125-135	"*When we share things in confidence…and come to find out the church person gets hurt or has church hurt… and they end up hanging your dirty laundry and using it against you…it makes it very difficult for ministers to want to have anyone that*
OVERWHELMED WITH NEGATIVE THOUGHTS		
Felt overwhelmed	9.319	"*So, I was runnin in the red, all the time.*"
Felt trapped	6.18	"*We get caught in the trap and we can't ask for help-uh, we feel like we can't ask for help, I felt like I couldn't ask for help and that happens a lot in ministry.*"
Suffered in isolation	21.819-824	"*I don't know, that's the scary part…nobody knew that [he was contemplating suicide], nobody knew I was thinking about, ya know, blowing my brains out or-or carbon monoxide poisoning with my vehicle."*
Felt helpless	8.256-260	*"You're in some sort of cycle, mine happened to be a cycle of addiction…you can't get out of this cycle…you're in the bottom of an empty abandoned well, and it's cold, and wet, and dank…and nobody's there, and there's no way to get out, and you're helpless and hopeless."*

Being deep in a mental a mental health episode felt like God wasn't there	18.705-708	"*You lose sight of how God sees you…if one of my kids is struggling…I would-you know my heart would break and I would wanna help them…but I didn't feel like that in my-in the time, even if someone reminded me, it…just couldn't-couldn't sink in past the cloud of fog around my brain or self-worth…so hopeless, helpless, worthless…um shame.*"
Felt like a failure & personally responsible for his inner struggles	18.653	"[I felt] *shame, guilt…lack of self-worth…I'm a piece of crap ...*"
Blaming self for not attending to problem sooner	12.427	*"The guilt is-the guilt comes from thinking, could I have done something different, could I have noticed it sooner, could I have asked for help sooner…there's guilt and shame that comes out after that."*
WHAT NEEDS FOR STABLE MENTAL HEALTH		
Initially ashamed of needing psychiatric interventions	13.478-484	"*Great, I'm on a crazy pill…I'm never gonna tell anybody that I'm on an anti-depressant…now I've got the stigma of medication… [i] got to a point that [I] was willing to do anything.*"
Being diagnosed by a professional helped alleviate feelings of guilt	13.466-470	"*When she [the counselor] was able to point out that it was my strength's that caused this [the depression], and [it was] not a weakness in me, that made me feel much better…there was a huge relief at this point.* "

		"I'm so self-aware…I've learned much about myself…I'm…aware of how anxiety and depression work together in my life, so I…write checklists of pages of [a] *notebook and when those checklists get too long, I become overwhelmed.* "
Realized keeping a task checklist initially was helpful but eventually became burdensome	15. 546-552	
		"*When I went for help thank God that [he] put me in a perfect place with perfect staff and elders that surrounded me…then I had to see a counselor twice a week and see a psychiatrist once a week, and…I had to [sign a] power-of-attorney or…some sort of-of HIPPA agreement that they (the church staff) could check-in…on me and ask…how I'm doing. [I didn't] have to give] too many details, just [enough for] them [to] say, "He's on the right path, he's doing well, or he needs more help.*"
Accountability to others is important	19.745-749	
		"*You're clickin on all cylinders, and able to get stuff done, and feel good…family's good and everybody can see a difference in you…and you seem happier, and you look back and, "Man, I was really…down there, I was really in the funk, and I was in there for a long time*."
Fully functioning mentally, emotionally, and behaviorally	11.397-401	
THEME 4: CHURCH INVOLVEMENT		
		"*Not being able to outreach to anyone, there's nobody objectively to say, 'Hey, you've got way too much on your plate…[even] if you just took five things off your plate right now, you'd still be too busy'.*"
Didn't feel like he had anyone to keep him accountable	6.177-179	

Extremely offended by the lack of empathy from some church people	17.635	*"[When] the next person [in ministry] comes up to me and says I need to read the bible more and pray more, I'm gonna punch em' in the throat, because that's not…the…if that was the answer, then I would be done…feel better.*"
Discouraged from hurt by the chu	4.125-135	"*When we share things in confidence…and come to find out the church person gets hurt or has church hurt… and they end up hanging your dirty laundry and using it against you…it makes it very difficult for ministers to want to have anyone that they can trust."*
Having the church's support is key	22.854-58	"*The culture at the church that I'm at is one of grace [and our church values] people over programs, servant [leaders] [who are willing help], [a community of people who reach out and are willing to help with any needs]."*
Church culture can prevent or contribute to pastor's mental health	23.878-887	"*The culture of our church staff and our church…leadership is that we're gonna take care of people...it's okay to admit you're broken, and you need help…our church staff and culture is the one that's going to help…we're not gonna leave you hanging out to dry.*"

ELIZABETH OF STABLE CHURCH RELATIONSHIPS	**PAGE/LINE**	**QUOTES**
Knowing her church offered trustworthy & confidential mental health helped her feel confident, unashamed, & secure in her ministering position	6.269-271	"*In this particular church…I had the joy of working with a senior minister and staff would say*, "Oh gosh, yeah…go do what you need to do, you don't need to be here."
Healing is marked by a feeling ashamed of getting help and resting	6.292-296	"*Because I knew that I needed to be there* (at the therapist's office). *I needed to be away, get away from the situation and be where I could be a mess…get on this medication…I was okay to be there and away from the stressors, which weren't work.*"
Differences between church leaders and their congregations give potential for misunderstandings and conflicts.	22. 1104-1116	*"I was very unhappy* [in a previous church when] *they got a new senior minister who just made life miserable…it was so bad that I couldn't even stay in the worship service…hearing what the preacher was preaching was just sickening to me.*
THEME 2: THE CHALLENGES & TRIUMPHS OF CHURCH MINISTRY		
Disappointed education did not properly prepare her for the realities of leading a church	4.197-203	"*I think there's a lot of stress there...that's something that you don't learn…there's not a lot of education ahead of time for pastors just starting out…into ministry.*"
Being sure is doing God's will provides a strong sense of inner peace & self-confidence	16.791-805	I was always doubting what I should be doing [although] I've **always** been a strong believer…when I'm doing what I'm supposed to be doing or God wants me to…everything is good, I'm happy, I felt like, **this is where I belong**! [but] when I wouldn't have those feelings…I was feeling like 'why am I so miserable?' My thought was I'm not [tearful pause] doing [tearful pause] what I'm supposed to be [tearful pause] be called to do

Disappointed about conflicts within the church	19.966-981	One of the biggest issues with returning to in-person church services is dealing with "*lots of stress working with people"* because of differing opinions about how the church should be done leading to lots of "*unpleasant"* emotions. The loss of being able to come together in harmony despite different cultural beliefs is disappointing.
THEME 3: IMPACT OF LIFE & MINISTRY ON MENTAL HEALTH		
Typical ministry is marked by overwhelming stress	2.65-72	"*I do know that the ministry can be extremely stressful…dealing with people in all their situations in life…and having a lot* [of] *being on 24/7, that feeling of not being able to get away.*"
Felt hopeless about her situation	9.422-425	*"I just can't do this anymore; I can't be here…there was no way that I could do anything that would change my situation ."*
Mental illness episode is marked by severe isolation	7.349-356	"*When those depressive episodes hit me…it's almost like a shutdown emotionally…I just feel like I'm in a cocoon kind of, and feels numb…separated* ."
Comforted by the fact her mental health symptoms were just biological not anyway related to moral failure	6.259-268	"*I had major depressive episodes…it was* [during] *the third one I…finally said,* "*You know this is not me. This is not normal. There's no reason for me to be behaving or feeling this way. And so, I finally went to a doctor who said,* "*…we can get you some medication to help with that,*" a*nd to go through that experience of feeling…all of sudden just like myself again…the medication is helping.*"
THEME 4: BALANCING LIFE & MINISTRY		

Balancing priorities is important for stable mental health	2.73-77	I think a lot of ministers don't take care of themselves very well, as far as making sure that they have time off, that they have a good work-life balance [and] that they have good family support [because] if you give everything you have…to the church, to the ministry, you will not have a healthy life.
Another aspect of ministry is being pressured by external expectations making it difficult to maintain boundaries	3.112-117	"*It was a full-time job just dealing with the people…not preparing sermons…bible studies, not doing other kinds of things, but just counseling people, and visiting people and working on grieving funerals…it can be overwhelming.*"
She was comforted by thoughts of running way to cope with feeling overwhelmed by family & church obligations	16.813-837	"*I was sooo depressed…I would have an urge driving…on the highway to just keep going…I can now understand now how sometimes if the mental illness is there [thoughts] of just disappearing* [is reasonable]."
Having family support was very comforting	9.450-451	"*So luckily, I have had [the support of spouse] and my family, the rest of my family is very, very supportive.*"

PAUL THEME 1: PROTECTING THE PASTORAL IMAGE	PAGE/LINE	QUOTES
Denial of seriousness of the problem	5.206-214	"*I just kept telling myself maybe tomorrow will be better…I'm going to discipline myself out of this…I'm gonna work harder…we're gonna get on top of this thing…I just never could.*"
Questioned why he couldn't fix the problem	5.241-249 PARA	Because exercise had always been a part of my life, I kept telling myself that if I just got back into a routine, I'd be fine and could get through this. However, the issue was that I would begin on a Monday and then be unable to get out of bed on Tuesday. And it wasn't because my body hurt; it was simply because I felt physically and mentally exhausted and couldn't continue. And then the following day, and the following day, I was unable to do so. I was perplexed as to why I couldn't commit to anything.
Delaying getting help only made things harder to deal with	1.44-49	"*Masking* (our weaknesses) *makes it worse and leads to ultimate…breakdown* …[and] *instead of acknowledging and addressing it we avoid it and kind of suppress it and in doing so, it makes it just 100 times worse.*"
Feeling competent marked by others feeling helped by him	2.51-56	*disappoint people, you don't want to let people down…as church leaders we…always* [live under] *this sense of performance or approval that drives so much of what we do in unhealthy ways".*
Feared job was in jeopardy if admitted mental health struggles.		"*The fear for me as a leader is that people will use this* (him feeling overwhelmed from ministry) *against me…other people on my leadership team thinking that I'm no longer effective and can no longer lead the team and therefore maybe they try to take over leadership."*

THEME 2: COMING TO TERMS WITH THE PASTORAL IMAGE & ROLE		
Dealing with a new role as minister & managing family was overwhelming.	6.260-270 PARA	"*Transitioning into the new role* " and moving the family across town was stressful, and his children changed schools, which carried a "*weight for a father"* because "y*ou're putting them through this process of building new relationships, and there's the financial aspect of just getting into a new home, and it seemed like every time I turned around, there was a The problem at the church, people weren't getting along, and families were leaving."*
Disagreements over how the church staff responded to the COVID crisis, and the invasion of political rivalries caused inner struggles	7.328-332	"*I think* [dealing with administrative pressures] *led me to this really dark place where I didn't enjoy what I was doing anymore…all I was doing was putting out fires and I wasn't even doing that very successfully* ."
Feels a sense of responsibility towards peers promoting a false identity	3.102-103	"*Shame on us as church leaders for allowing the enemy to do that to us…for us not secure in our identity in Christ* ."
Shocked about church losses	4.157-158	"*I was sad* [and discouraged] *because we were losing people as a church* ."
Training and education are problematic	3.135-136	"*Every person brought a new problem to my desk that I didn't feel adequately prepared to handle.*"
THEME 3: CONSEQUENCES OF TRYING TO UPHOLD A FALSE STABLE IMAGE		
Loss of purpose	7.333-336	"*So, this thing* (church ministry) *that I had doing…since I was 19 years old…for the first time in my life, I was receiving no joy from it...that's when things got scary for me.*"

		"*I felt numb on the inside. I felt like I could not have any emotion…I did not realize all the effect that was having on me.*"
Repressed feelings	4.174-176	"*It made me feel more shame and more guilt…embarrassed because I'm not tough enough.*"
Discouraged, disparaging, and helpless	5.225-227	

Negative thinking led to emotional symptoms	4.163-164	"*I think the enemy kind of began to play some soundtracks in my mind that were broken* [and] *negative. I chose to listen to those more than I did the spirit of God in me. I just got really…depressed, discouraged.*"
Thoughts of wanting to escape	3.141-144	*The hardest thing for me is just to remember pulling up in the parking lot to a job I absolutely love and not wanting to come into the door* [or] *get out of my car and walk into my office* [instead]…*I could just fill my car up full of gas and drive anywhere but here.*"
Loss of priorities	3-4.150-153	"*Spending time with my family usually fills me and gives me great joy and yet it didn't.* [When] *spending time with my wife…I could only think about the emails that I was getting the text messages people were sending me* [instead of being] *present with her.*"
CONTROLLED AND UNDERSTOOD		
Overcame fear of exposure	9.398-401	"*I brought in our church council,* [and] *trustees and I shared with them. I restructured my staff to give me a little bit of support…and…protection…those things helped out a ton.*"
Prioritizing tasks	9.398-421 PARA & 9.538 PARA	He realized the importance of implementing and maintaining healthy boundaries for committing his time with family, self-care, and church ministry through a self-managed and well-balanced schedule, although at times feels like is in a "*crazy cycle."*

Having trustworthy peer support motivates him to share his problems	2.74-77	"*I think that we church leaders are willing to come before…the appropriate group of people to…present ourselves, so to speak, naked and unashamed.*"
Realized the potential impact if he had not sought help	8.380-391	"*I would have quit…I would have hit a breaking point…I could have had a stroke…I don't know [if] something really bad happened like that…I would have resigned* ."
Identifies pride as a barrier to safe & healthy living	10.455-459	"*It is crucial that pastors with thoughts of self-harm not delay in reaching out for help,* but "*I think that too many times,*" what gets in the way of suicidal pastors seeking assistance is, "*we just assume that we can get our way through it, we're used to being fixers* ."
Hopeful future	9.426-429	"*I feel like I have a life again…a little more optimistic…I feel good being able to now look in the future and…I can see myself in this position for another 10…20 years* ."

JONAH PASTORAL IMAGE OF STABILTY	**PAGE/LINE**	**QUOTES**
Pastors image of stability must be protected	12.539-545	"[Pastors need] *to develop a close-knit…some trusted friends* [because]…*when you're a pastor…if you reach out for help, it's going to get around…folks might get the wrong impression our pastors' cracking up.*"
Overworking leads to burnout and mental stress	2.74-81	"*I might work a 12 hour, a 15-hour day but if I give in to the temptation…there's always someone else that I could pray for…reach out to* …[write] *another note…there's always another cause that I can educate myself about and I can just get burned out for what seems like very good reasons. I was just caring…trying my best, and of course, we know that in the end that doesn't bode well, it results in burnout or resentment, or a sense of failure.*"
Poor insight into people is problematic	9.397-399	"*If you're not wise enough to figure out who those people are that you can trust and learn to lean on them, you can get fairly lonely because you begin to think, maybe I can't share this with anybody.*"
Blindness to weaknesses sets up for failures	3, 2.102-103 & 90-94 PARA	"*Awareness of one's tendencies or weaknesses…is pretty important"* especially if "*a person* [has] *a savior complex…if you're not careful* [or] *aware that you've got that sort of leaning…you can fall into"* believing that you are the change agent in people's lives rather than God. "*My strength had become my weakness"* he connected with the story of Greek legend, "*I love the mythical story of the mighty strong Achilles"* who died from being shot with an arrow in a seemingly not critical part of the body, his heel, "[but]…*the point of the story is that his strength, his invincibility and the rest of his life caused him to neglect this one*

THEME 2: THE MENTAL HEALTH ISSUES AS A RESULT OF OVERWORKING IN THE PASTORAL ROLE		
Overwhelmed by the lack of insight of his depressive episode	7.315-321	"*I prayed, I engaged in serving others and that helped a little but not much…I didn't know at that early stage that it was depression. I honestly thought I was losing my mind…I was going crazy…this is it; I don't know what has happened to my mind but…I'm finished in terms of being a productive an individual in this world* ."
Problems thinking	5.227-238	"*I couldn't control myself, my brain worked differently, I was sad…anxious…I didn't know what was wrong…I rapidly went to complete sadness, despair, and even suicidal thoughts. I was in a deep depression* ."
Severe depressive episode	6.261-266	"*Everything was sad…I was sad, house was sad, my marriage was sad, my church was sad, the world was sad…the feeling of sadness…was something I had never experienced before... just the feeling of hopelessness, it's hard to describe but it was very real* ."
THEME 3: COPING STRATEGIES		
Unhealthy lifestyle is problematic	4.194-195 PARA	Pastors can easily become overwhelmed when not taking care of themselves or balancing family and church functions and instead they are *"pastoring, pastoring, pastoring, working, working, working, and then collapsing* ."

Poor coping can have dangerous consequences	4.177-178 PARA	"*If we're not actively trying to"* be intentional about maintaining healthy boundaries and priorities to include proper rest, "*we can fall victim"* to suicide.
Despairing of no clear solution to help suicidal pastors	4.151-154	"*Secrets are deadly, and secrets can kill,* [pastors are] *guilty of keeping their own maybe because of that pressure they feel, they could blame it on their congregation, but some of it is self-imposed as well.*"
Healthy boundaries are important	10.476-478	"*I've made self-care a priority that I let people see [even though] …it's counter-cultural and for some folks have a hard time with* ."
Realizes is not responsible for fixing everybody	5.210-214	"*Even if we're not doing anything, God's gonna take care of the world, which is a pretty important theme to get clear about, yes, God wants me to help…but I'm not the only person that God's depending upon, and God's able to make things happen, even if I don't come through* ."
THEME 4: THE IMPORTANCE OF A BALANCED SUPPORT SYSTEM		
Accepting interdependence on God	9.425-426	"*Instead of the one who had to be in charge or have-it-all-together, I realized, "Hey, I'm just another child of God in need of God's help.* "
Support of peers is important	12.539-540	"*A close-knit group…keeping together some trusted friends that one can talk to* ."
Betrayal is problematic	8.393-395	**"***What I've discovered is that some people can handle my humanity, and some can't and that there are some people you can trust with stuff and others you can't* ."

Willing to let go of preconceived negative views of mental health is important	11.523-528	"*There are theologies that lend themselves…loath to reach out to the medical community…some folks may be under the impression if I pray enough and if I trust enough, God will heal me…God can do anything…but I think medical technology and pharmacology are ways that God has blessed us and helped us* ."
No longer thinks more highly of self than he should	11.495-501	***"****I feel good about…my mental health and what I've learned about my own mental health crisis [which] has allowed me to experience a new level of authenticity…I've released some unrealistic or grandiose hopes or visions about always having-it-it perfectly together or outpacing my peers. That's not a big deal to me anymore,* [I] *just want to serve God and do my very best* ."
Improved self-awareness	11.502-510 PARA	"*I've reached an awareness" from readin*g, "*the book, The Wounded Healer, that phrase resonates with me in the sense that when one is wounded, one is different, I see that that,"* and as it relates to, "t*he story of Jacob and his wrestling at the river Jabbok that he was different from that moment forward".* Just as Jacob, "*walked with a limp,* "*I in like fashion walk with a limp in terms of my mental health and my experience of what I've been through but…I'm a different person, a better person on this side of it.* "

AMOS	**PAGE/LINE**	**QUOTES**
THEME 1: CHALLENGES OF THE PASTORAL ROLE		
The unrealistic expectations of others are problematic.	2.60-63	"*They want me to be* [in a] *positive way, they want me to be an example, I have to do everything*, [and] *if I fail*, *they don't believe in me anymore. That's not right…I can fail.*"
Overwhelmed by helping others.	2.48-55	"People are bringing all their problems to me thinking that I'm the only one who is able to solve all of their problems even though I am human like them…so to me it's heavy, it's heavy…I'm distressed because of that heavy carrying of all the problems of people."
Fear of being seen as incompetent	5.207-210	"*I don't want to share with people…tell people I'm sick…because they think I have the power to heal myself.*"
Feels unappreciated and used selfishly	4.149-152	"*I felt disappointed like people are exploiting me…exploiting my kindness, my openness.*"
Loss of self-confidence in pastoral calling	3.133-136	"*I made a mistake; I should not be their pastor…I should do something else; this is too much…because of too many problems going on I'm tired…I made a mistake.*"
Accepting the challenge of pastoral role	6.263-265	"*Working with people is not easy because there is a kinda impact on my health…it's killing me, all the problems of people are killing me, but I don't want to give up.*"
THEME 2: MENTAL HEALTH EPISODE		
Cultural stigma is problematic	5.222-223	"*Most of us don't preach about these things, it's a-they think it's a kind of taboo, it's taboo.*"

		"*I'm blocked, I'm stuck, I cannot move…I feel like I'm stuck in the same place at the same time, I don't feel like myself.*"
Hopeless and helpless	6.230-232	"[Felt] *sadness, especially sadness…very sad, sad, sad* … [off and on] *for years and years."*
Episodic severe depression	4.164-169	"*I'm not going to talk to people anymore, I would like to be alone for a time.*"
Isolation as a negative coping	5.183-184	
THEME 3: PREVENTATIVE MEASURES		
Pastors should not allow shame to stop them from seeking assistance	7.278-281 PARA	Suicidal pastors "*should go to the hospital to see a specialist, talk to them instead of saying, "I'm just going to pray," no, go outside, go the hospital, see a specialist so they can help you.*"
Church support is critical to stressed-out pastors	7.284-301 PARA	His church plays a critical impact in helping him maintain a healthy and stable mindset, "*some are my friends, they talk to me…they laugh with me, they don't come to me just to tell me their problems,*" his church is there, "*to save my life.*"
Accountability is a key aspect of mental health	2.88-94	"*As a pastor, I have to have my own pastor, my own minister if I have a problem, I have to go them and then share, but most pastors don't do that, they don't have the one advisor, they don't have a counselor…you have to have somebody that you are able to share with what's going in you.*"
Social relationships are key to his emotional health	6.244-245 PARA	His family is an integral part of his mental health, "*they are a backup to me,* [I] *rely on my family.*"

HEZEKIAH	**PAGE/LINE**	**QUOTES**
THEME 1: CHALLENGES OF THE PASTORAL ROLE.		
Cultural expectations of pastors are problematic	3.116-119	"*I was a pastor…[addicted] to peformitnism which the church loves…they promote you and foster that toxicity.*"
Role of the pastor is problematic	4.209-215	"*Ministry is just a relentless and unforgiving job, there's just a short list of other jobs that invade your life to the degree that ministry can; so that depletion, that idea of pouring out without pouring in, which means I have to do a magic trick, constantly…I was in a profoundly depleted place emotionally, spiritually, I wasn't taking care of myself physically.*"
Disappointed that the role of pastor is not as it should be	2.56-59	"*We've created this thing in the American church where our Shepherds are celebrities instead of Shepherds and we have forgotten that they're just sheep with a calling.*"

THEME 2: CHALLENGES OF TRYING TO UPHOLD THE IMAGE OF STABILITY

Ignorance of issues is problem	5.225-226	"*I think I had a blind spot to how bad I was doing."*
Hiding his issue is problematic	6.283-286	"*I showed up and preached on Sundays- now the people closest to me, my staff…our board knew, but ninety-eight percent of the people I was preaching the word to every Sunday had no idea, which created such a feeling of aloneness.*"
	3.138 & 141	pastor is supposed to be perfect causes a heavy burden that feels "*cancerous"* and "*creates a secrecy around aloneness"* when a minister is struggling with a mental and or
Fear of judgment	PARA	emotional issue.
Fear of job loss	9.428-432	"One of the reasons that it took me so long to be aware is I was afraid of a couple of my board members who were in their 60s or 70s they're gonna see this [depression], as such weakness, I'm gonna lose my job, lose my ability to "*One of the reasons that it took Me so long to be aware is I was Afraid of a couple of my board Members who were in their 60s or 70s they're gonna see this* [depression], *as such weakness, I'm gonna lose my job, lose my ability provide for my wife and kids*."

THEME 3: EMOTIONAL AND BEHAVIORAL CONSEQUENCES OF DENYING THERE IS A PROBLEM		
Questioning faith	3.110-111	"*I was a pastor, it was a crisis of faith, I was doubting the goodness of God* ."
Excessive isolation	6.281-282	"*The aloneness factor…is huge for pastors* ."
Struggles during severe depressive episode	6.271-274	"*I realized how dark it was…on top of the sadness…the weakness thing makes the depression worse and worse and worse* ."
Overcome by negative views	5.263-268	"*Feelings of failure…and then feelings of profound shame…I spent more hours today believing I'm better off dead than alive* ."
Hypocrisy problematic	5.260-262	"*There were profound feelings of hypocrisy…I'm proclaiming a gospel of grace that I doubt…I doubt he's really that good of a Father* ."
THEME 4: SUPPORT OF THE CHURCH AND WILLINGNESS TO BE VULNERABLE		
Accepting need to be vulnerable with trustworthy peers	7.328-335	"*I have a group of guys that 'm daily in touch and it's dark I'm gonna speak that out, and every person who does life with me knows…they always have the freedom to…ask me how I'm doing, and they have the freedom to not believe my answer and ask more questions…that's living in daily awareness and openness…to be accountable* ."
Disappointed many churches no supportive of pastors with mental issues	5.242-250	"I had a support system…I just don't believe it exists in most churches…I've gone to bat with elder boards on behalf of other pastors and asked on their behalf for a sabbatical and [these elder boards would respond] 'well if he's not even healthy, he needs to resign'…I grieve for the unhealthy structure, I believe we've set up guys to implode either emotionally or psychologically or morally."

THEME 1: STRUGGLES TO UPHOLD PERFECT PASTOR IMAGE

Trying to uphold external unrealistic expectations of being available 24hrs is problematic	8.379.381	"*One of the elements of ministry that can be…overwhelming…is this idea that they are always 'on,' always having to be ready to go at any moment* ."
The downward spiral of trying to uphold the perfect pastor	2.56-50	"*There is this conundrum…it's a vicious vortex…a funneling effect* " and "*at the end of this vortex many* " church leaders "*can find themselves spinnin' outta control but they don't know whom to go to…or talk to because they're the ones that are supposed to have it all together"*.
Fear of job loss	9.428-431	"*The mindset that leads into problem-stress, anxiety, Fear, suicide with pastors* [is] *they feel like an orphan*, '*Nobody understands me, and if I say anything, they're gonna punish me, I'm gonna lose my job…my… tenure…my license*."
Belief could handle everything On own problematic	6.266-293	"*Well, if I can just fix it…there was also a lot of criticism of myself…because I should be able to do this better …I'm skilled, I'm talented*" but when found himself Not being able to "fix" his mental health issues on His own, "*it just reinforced the false belief that I wasn't qualified" to do the work of ministry and this made him feel like, "I'm a failure…I…was never satisfied*."
Seeking external acceptance and validation problematic	8.398-401	He struggled with setting boundaries because, " *I wanna be liked, I wanna be loved…but the difficult part* [is*] the inability to say no at times*."

THEME 2: THE COGNITIVE, EMOTIONAL, AND BEHAVIORAL CONSEQUENCES OF BECOMING OVERWHELMED IN THE PASTORAL ROLE		
Hopeless, helpless	5.233-237	"*During the panic attack…I felt as though, 'I'm not gonna get out of this, there's no way for me to recover from this and it just continued to escalate and spiral like a vortex…spiraled out of control* ."
Feeling like a failure	4.189-190	He felt like a failure when his ministry work did not turn out how he expected, "*I made a mistake, I shouldn't have done this, I'm endangering my family* [won't be] *able to provide for my family* ."
Passive death wishes comforting	5.243.245	In the context of contemplating suicide, "*For me, it may not be a bad thing to just go back to sleep and not wake up*."
Wanting external validation for ministry is problematic	7.311-319 PARA	Struggles at times to accept that the work he is doing for God he will not see or receive any physical manifestation of a job well done in an expedient manner stating, "*What we're involved with, it's the long path…what I'm doing today, I won't ever see the end of it*," but at the same time, he paradoxically feels excited by his current work in people's lives that he may never witness the future outcome or be applauded for, but also wants to be affirmed for the ministry work he is doing now, "*man, I wanna be able to say…this is what I did today, look at it*!"

Balancing church ministry and personal life problematic	5.207-216 PARA	He was confronted by one of the doctors after multiple trips to a local emergency room for what he thought was some serious medical condition which in fact were panic attacks and his response to the doctor was, "*I'm runnin a small business, the church, I'm responsible for the lives of a hundred and seventy people. Everything about it…I'm drinking way too much caffeine; I don't have anybody to talk to…I feel like a hypocrite*."
Negatively impacting family is problematic	5.248-252 PARA	He felt extreme dread during one of these panic attacks, "*There's a lot of fear…not for me…but for my family…I'm worried about my kids growing up, worried about how they're gonna handle the fact that I'm gonna die* ."
THEME 3: MAINTAINING STABLE PASTOR MENTAL HEALTH SUPPORT		
Trustworthy support to be accountable is key to stable mental health	9&10.439-464 PARA	He discovered that being vulnerable was not a sign of weakness but being willing to share his innermost thoughts and feelings, no matter the content, with peers who are trustworthy and have experienced the same pastoral pressures, helps him stay mentally, emotionally, and spiritually grounded in truth.

No longer afraid of being judged	9.433-435	He no longer feels ashamed nor tries to hide struggles, "*I've taken the approach…to be extremely forthright in not [talking about] only what I've been through but what I'm goin' through today!* "
Handling the 24hr nature of ministry takes mindfulness and priority setting	11.510-517	He practices what he calls, '*the ministry of presence*,' "*Being present in the moment…as opposed to having my mind wondering about 'well I should be doing this, and why didn't I do that, oh my Gosh! I forgot to do… these types of things* ." He utilizes this philosophy because he accepts the challenge of being a church leader as his job is, "*never over ",* he'll *"never reach a point* " of completing all that God has planned for him because "*there's always something to do* ."

ISAAC	PAGE/LINE	QUOTES
THEME 1: DISILLUSIONED MINISTRY CALLING		
Dealing with other people's issues is problematic	2.72-76 PARA	"*People are complicated*," he states as people come with various and intricate problems, some self-made, and what makes it difficult is people come with unrealistic expectations "of especially pastors" to help which, "*just creates stress from all those angles* ."
Struck between knowing can't fix everyone's problems but still trying to present self as one with all the answers	3.101-107	"*It makes me feel ill-equipped…I've had training…schooling and seminary and years of experience but that doesn't mean I know how to handle every single situation…so stepping into the lives of people and not really having an answer all the time but looking for an answer is stressful* ."
Not having any other career choices is extremely problematic	7.297; 299-300; 318 PARA	He admits that in "*the last 12 years* " especially when he is having a mental health episode, he questions his calling as a minister, "*my identity, my ego takes a hit because the thought of jumping into something completely different is…scary…it's terrifying* ."
THEME 2: THE EMOTIONAL, MENTAL, SPIRITUAL, AND BEHAVIORAL CONSEQUENCES OF OVERWORKING		
		"*I guess I'll label it depression…that I've experienced is more seasonal* …[as] *my ministry runs full on during the summer and then slows down during the school year* [so] *in the fall for at least a week if not a month…I get into this kinda funk not feeling needed…wondering if what I'm doing is worth it…wondering if I should be in ministry at*

Staying busy as a way to cope with feeling empty	5.229-230	"*Whatever would come my way, I would say 'yes' to it, just to try to fill some of that void of…emptiness* ."
Emotional episode marked by spiritual disconnection	6.282-289	"*Feeling disconnected from God…disconnected from what I believe is the source of life and joy would bring on feelings of not having life and joy* ."
Asking for help problematic	8.361-373 PARA	"*In the lowest of the days I just wanna be alone even though I know that's not the best place for me…my mind convinces me that's the right move*," rather than outreaching peers' support, "*I don't want to outreach them because I don't want to bother them*," although, "*the ones that I have told about these times they've been great…but when these times come, I'm not always the best at…reaching out* ."

THEME 3: CHALLENGES OF CURRENT LIFE AND MINISTRY

Asking for help problematic	8.361-373 PARA	"*In the lowest of the days I just wanna be alone even though I know that's not the best place for me…my mind convinces me that's the right move*," rather than outreaching peers' support, "*I don't want to outreach them because I don't want to bother them*," although, "*the ones that I have told about these times they've been great…but when these times come, I'm not always the best at…reaching out* ."
Considering the future prob	8.381-385	At the time of the interview, he felt unsure and fearful of his future in the ministry and quested whether he should continue in church leadership given he felt "*stuck* " in the position rather than fulfilled, *"I don't know what the future looks like, it could be I'm doing the same thing for another…five-ten years* …", and thinking of this is, "*not exciting to me…my future seems…a little foggy* ."

Aspects of church support	9.395-397;400-401 PARA	"*I feel like I have the trust and confidence of people in my workplace…I'm not sure if that's everywhere though…I still think in churches we're behind on talking about* [church leaders with mental illness] *…when you're a pastor, it's kind of taboo to have real human issues…even at our church…for pastors to confess* [emotional issues] *I think some people would be shocked…and afraid.* "

APPENDIX C
SAMPLE TRANSCRIPTS

RES (Q1): Yeah, okay, so cool beans and so Like I said, I'm going to through this conversationally as possible so um I'll just start off you know with this first question is like, basically you know, what does the term mental illness mean to you? Like, how do you define it?

ABRAHAM: Hu.u.u.m, (huff) Mental illness. To me mental illness is just umm golly, I've never just really thought about defining it, umm, I would say it's when someone…has something going on in their life where in their mind they're not able to cope or handle things in what is normally deemed a umm normal way of thinking or handling things. umm Hope that like making sense umm where when someone is acting not in the normal state of mind for themself, or even what we would say is the normal state of mind for a society. That could be some of anything, sleeping too much, a a being snappy when normal people wouldn't snap. umm just not acting in a normal state of mindset for themselves or even as what we would deem properly with the majority of people.

RES: oh, okay and when you think about normal, how would you define that? (GOING DEEPER QUESTION PROMPTED BY P1 STATEMENT)

ABRAHAM: Yeah, see that was the problem. That's why I didn't like the question cause I knew I was going to say normal [grunt] NORMAL umm (long pause) normal for the person…umm (long pause) normal for the person I would say would be when the individual how the.e.y. act well see, it just brings up more questions that I would ask. I would say act in the same way of thinking but then my definition would be the same. umm (long pause) Normal would just really be when the person is not acting out of character. umm Able to rationalize and think logically umm on how they would handle things or have even handled things in the past.

RES (Q2): Now yeah know, moving on is like experts report that church leaders are stressed and have emotional problems such as depression, anxiety. What do you think about this?

ABRAHAM: I believe that's a fact. umm I would say a most ministers, clergy are depressed, being honest even have mental illness umm. Because normally, we're the ones that people come and talk to but then at the same point, we don't go and talk to anyone else to try to help alleviate all the things that we take in. umm We CONSUME everyone else's problems, help them work through it, but then we don't have a healthy outlet… Sometimes we have an outlet but even if the outlet is unhealthy, it will st.i.i.l.l been even cause or incur some of our own mental illness.

RES: When you say that, does it make you think about anything else? (GOING DEEPER QUESTION)

ABRAHAM: ah, well, I've done it, I've, I've, I addressed my own personal mental illness issues and it made me reflect back on how if I would have had a healthier outlet, whether it was me going to therapy, exercising more, taking my own time, uh vacation time and everything, how things would be so much better for me.um but since I didn't, I caused some of my own mental illness issues and even mental breakdowns.

RES (Q3): and so, Picking back on that, there's several news reports all over the world about pastor suicides. What do you think about this?

ABRAHAM: uhh It's more of a reality um…because of…because of the stigma of ministers having it ALL THE WAY TOGETHER, umm having no issue, no problems. umm When they do start addressing other people's mental health issues and try to help them cope, then as a minister I will feel like I can't open up to anyone because then they will see my flaws and issues. If they see mine, then they may not allow me to help them. and so, I become more mentally unhealthy and because of that, then a lot of times the only way out that we see is suicide ummm.

You can only drink so much, become so much sexually immoral, and then the more you drink, the more sexually immoral you become… then the more likely you are to commit suicide because you still feel the guilt… and know the sin that you're in, and so then that cycle becomes so much that then you feel as though the only way out is suicide...That is actually a quick fix because you don't want to cope with the sexual immorality, the drinking because then you'll get that fix but then you've got to cope with all the other baggage that you've taken on from other people.

Since you don't want to cope with the help you've given people than your own issues the only solution is suicide….and I say that because that's where I was.so I'm looking at it for me, literally, personally.

RES: Do you feel uncomfortable? Can you tell me more about that? (GOING DEEPER QUESTION)

ABRAHAM: Yeah. I had got um I've had probably a couple, probably about I think three times umm that I've contemplated, um one time that I tried. umm the first time that I tried I was about 3.0.0.0 I was 31, maybe I was 31 years old, so about 10 years. No, I was 29 the first time. I was 29 years old, new to being a full-time minister uh at the church, was already dealing with that because I was the youngest preacher then in the metroplex that took over the work, all the pressure. I was still working two jobs was single. Everyone was like, "He needs to be married." umm Then just everything that came with it and doing pre-marital counseling and marriage counseling were even the stress within it where one party would want to come to me, even though I was single they knew I was going to come with the word, so whatever the word of God said was that's it. Then the other party didn't want to come because I was single, umm, so BATTALING THROUGH IT umm.

School, dealing with my own personal issues because at that time, I was accepting being molested as a kid. uhh knowing that there was NOTHING I COULD DO ABOUT IT about that because the person who did it still went to the church where I grew up at umm but I'm 29, so the Statute of Limitations had passed.SO COPING WITH THAT, umm. Just the pressures of being a young minister, going to school, trying to work on a doctorate, umm EVERYTHING so.

Started drinking...Drinking wasn't helping becoming sexual immoral, but then doing those things, I felt guilty because I know I shouldn't be doing it. and I remember one day, I GOT SO DRUNK that I passed out at my house and when I came to, I had the gun in my hand, but the gun had jammed…. umm so I went ya know and got help, umm and went through all that. and that was like my first incident umm Then my second wasn't actually too long ago.

Umm Didn't know what was going on with me. I found out later that I had chronic Lyme disease. umm I thought I was just going through a depression umm and had been uh medicated by my primary care physician, um who did the testing on me and said I was depressed, highly depressed. Told me to go see a psychiatrist but I'm a full-time minister. Didn't make time to do it.

Helping everyone else. Ran out of the 30-day amount of pills. Didn't even tell my regular doctor who would have renewed the prescription uhh but didn't, so I ran out and so I was also going through withdrawals. umm Became very mentally unstable. umm Where I should have been hospitalized uh but because I am a minister and a public speaker, I worked for Child Protection Services at that time, I LITERARLY TALKED the psychiatrist out of institutionalizing me when in reality, she should have umm but I told her, "If you do, I lose everything," ca.u.u.s.e I worked for the State of Texas and they would have said, they wouldn't have fired me but they would let me go. Uh, let us just be honest.

uh the church where I was at, they woulda let me go because no one would have known she wanted to institutionalize me right then. umm I was in a very stressful marriage, umm which (huff) was PUSHING MORE the stress and the mental health issues. umm married to a nurse practitioner, umm who was dismissing me even though she knew the medication and things I was on. umm so I was in a very bad place umm where.

When I was contemplating to committing suicide, that's when I realized that I needed to go see a psychiatrist. and That's when I went and saw the psychiatrist and therefore, she wanted to put me in the hospital. and It was just because of the previous time. Cause I think if I wouldn't have my first scare at the age of 29, I actually would have killed myself, and This was back in 2.0.0.0.18, it was January 2018.

Then in my last incident is when figured out well, we thought it was depression, I got better with all of that umm, but I continued to get sick. umm went through a divorce cause relationship wasn't healthy umm. I wasn't drinking anymore, wasn’t no sexual promiscuity or anything. I was just sick. umm I was losing the ability to walk. Ahh, I was having massive umm migraines, and headaches. Couldn't sleep at night, umm

and around this time, I was probably put on about 30 different pills that I was taking every day for medication because I was diagnosed with rheumatoid arthritis, fibromyalgia, and then in the end, they tell that me I had ALS. Soo I'm like, "Well, that's not the way I want to die." Umm, and I happen to just be ya know having a mental breakdown and I was literally about to kill myself,f and a preacher friend of mine popped up in my apartment umm he said umm something just told him to come by uhh, so he talked me off the ledge ya know and helped me go get some mental health. At that time, but then we also found out that I actually had chronic Lyme disease and that was also messing with my brain umm.

RES (Q4): Okay. So now moving towards more personal now, um, could you describe your own thoughts and emotions during the time of your own mental health episode?

Elizabeth: Um, fairly recent-- I have been at this position in this church for 13 and a half years. And, um, I have had a couple of instances during that time, probably several instances of, uh, depressive episodes and I've had I- one-one of them was going through a medication change, ya know, had to go off one medication for particular reason and start up on another one. And there was about a two-week period of time when I-I just cried constantly. And I knew it was- it was chemical. Uh, I mean, there were things going on that were stressors in my life, but that wasn't no- that's not normal for me.

And-and when I have, uh- I-i had major depressive episodes, um, starting when I was in college. And when I-I recognized, I think it was like the third one that I actually experienced when I finally said, "You know, this is not me. This is not normal. There's no reason for me to be behaving this way or feeling this way." And so, I finally went to a doctor who said, "Oh my goodness, yes. [laughs] you We can get you on some medication and- to help with that," and to feel- to go through that experience of feeling you'll- all of a sudden just like myself, again. Just feeling normal, you're singing as I drive the car and whatever, um, instead of just balling while I'm driving for no reason, uh, I knew that, okay, yeah, the medication [laughs] is definitely helping whatever is going on there.

Um, but in-in this particular church, I had the- just the joy of working with a senior minister and staff who would say, "Oh gosh, yeah, go, ya know, go do what you need to do. Uh, you don't need to be here." Um, normally, if things were just the stressful things at home, then by the time I got to work, even if I felt like, "Oh gosh, I can't go into work today. I just feel horrible." And by the time I got to work, I felt fine. And all through the day, ya know, working with the people I work with and doing my job, I just thought, "This is wonderful. This is where I need to be." And then I didn't have to face [chuckles] whatever was going on at home until I was headed home again.

But there were a few days when I-I drove in, and I sat in the parking lot and I could not get myself pulled together to come in. I could not. And so actually y'all called or texted. I kept- I think I texted my boss who was in-inside and said, "I-I'm just, ya know, a mess I can't come in." And he came out and talked with me in my car and I had already called my physician and my counselor, my therapist, and my neurologist. I had a neurologist at that time and ALL THREE of them said, "Oh, you need to come in IMMEDIATELY." My therapist that normally I don't go to her all the time. I just, you know, every now and then I'll go see her for a few sessions and then there'll be another year before I even see her again.

And she's hard to get into she's-she's very, uh, busy, but I called her, and she said, "How soon can you get here?" Ya know,[tearful] she-she cleared her schedule. So- and I ended up, um, going home and packing a bag [chuckle] and driving to Tulsa. I live in Fort Worth, Texas. And I drove to Tulsa where my family lives. And because I knew that I needed to be there. I needed to be away, get away from the situation and be where I could, ya know, I could be a mess [chuckles] and-and, uh, and you'll get on this new medication or a different dose or whatever, until that kicked in. I was okay to be there and away from-from the stressors, um, which weren't work.

They weren't my-my ministry that was stressing me at all. There were home situations, um, that were STRESSING me, uh, to the point of breaking. So, ya know, I had my neurologist saying, "Okay, you need to change that situation immediately. Or you're going to crack, you know, completely." Um, and my physician and my therapist, you know, saying the same thing, "You need- we need to take care of this immediately and you need to get out of there and we need to get you on some new medication. And, um, you need to just take some time off." [chuckles]

And so, I was able- I had the luxury at this place, ya know, to have a supervisor and a staff that were very, very supportive and saying, "Okay. Yeah, you go, we'll be okay here. We'll, you know, we'll have everything covered. Okay. And you just, you know, take the time you need, if it's three days or if it's a week, whatever you take, what you need before you come back again." And so that- but they all- they knew, at least, my supervisor and the people I work closely with already knew of my condition and knew that I- and they knew of my home situation and what was going on there.

RES (Q5): Okay and during the times where the episodes were like, really-really ya know, bad, what did you think to do about it? Like you're feeling this way, you're thinking like this, what did you think to do about it?

AMOS: Some people think about…killing myself, "I'm going to kill myself." (long pause)

RES: Did that thought-kind thought ever cross your own mind?

AMOS: Yeah.

RES: Uh hu, any other thoughts, I mean not-not thoughts, any other things that you thought to do?

AMOS: Uuum, not to talk to people. I say I'm not going to talk to people anymore. So, I would like to be alone for a-for a time, not talk to people too much [cross talk]

RES: Uh hu, like going on a sabbatical?

AMOS: Yes.

RES: Did you thought-think of asking for any type of help?

AMOS: Any type of…Oh yes, maybe going to hospital to see a doctor, I'll say I'm goin to see a doctor, that's here, but back home in Africa we don't do that. I stay home just like that; I don't need to go to the ah to see ah-to the hospital to see the doctor. I say, "I'm going to stay home." And then tell my wife "I don't want anybody to come here. For about one week, I'm staying in my house, thinking about this." Reading the Bible, seeing what can I do? You see, it's kinda isolation again.

RES: And it's interesting your experience so but in Africa, do they have psychi-I mean I haven't looked into it, do they have psychiatric hospitals there?

AMOS: No…No…not like here. (long pause). Maybe it sometimes we have ah the older people, the older people-people 70, 80, ah-65, they are our psychologists, (laughs) we go to see them to talk to them. To say what happened, and what can I do, and they say, "okay" things like that but it's not like here.

RES (Q6): Okay, and moving on, so you've already talked about this a little bit um what do you think contributed to your mental health, I know the pressure from the outside is something you mentioned, is there anything else, when you think what- why did you have all of these problems inside?

AMOS: It's ah because I don't want to share with people. Ya know, we as ah pastor, ministers, I'm talking about African pastor and minister, when I'm sick, I don't want to tell my people that I'm sick…as I said before because they think I have the power to heal myself.

So, I don't want to tell them that I'm sick, eh, because they think I'm-I'm-I'm-ah close to God. I'm close to God. I don't want to tell them. That's a mistake. Because I know I have to people that I 'm sick I have a problem too as a minister, I'm like you, I can get sick.

But because we don't want to do that to share with that, that we have a problem ourselves inside.

RES: Uh, Uh, anything else besides not sharing?

AMOS: Uuuh (long pause) Not-not preaching about these kinds of things. Some preachers don't preach about these things, as you said. Isolation is not a good thing, to keep things in your inside of you and not sharing, it's not a good thing. Look-look at, this is the will of God, we have to do this-to do this.

And most of us don't-don't-doon't preach about these things, it's a-they think it's a kind of taboo. It's taboo.

RES (Q7): Mm-hmm. Okay. All right. And so, moving on, um, you mentioned one kind of word through your talks so far. But what did you think about yourself during this time?

Jonah: It was very-- well, it was veery humbling, but, um, but in a good way, um, in the sense that it sort of-- it didn't change-- Well, I don't know. Uh [background noise], it probably did change my preaching a little bit in the sense of me being more compassionate and realizing, "Wow, some of these people are REALLY suffering and now I've been exposed to this. And I'm aware of how bad it can be." So, I think it made me more, um, compassionate. Um, but having, um, a foundation in the scriptures and in the faith, um, I was now able to-- Uh, let me put it this way, When I was- when I was ready to see it, there were some very, um, affirming messages there for me.

Instead of being the one who had to be in charge or have-it-all-together, I realized, "Hey, I'm just another child of God in need of God's help." Annd although I have experienced a great deal of success and-and admiration and-and had, uh, sort of a steady climb up the professional ladder in our denomination, I too am, um, vulnerable, um…, to all kinds of things. And I had-- uh, I had begun years before noticing and taking special note of colleagues of mine that had been….relieved of their duties because of, uh, moral failure.

Generally speaking, uh, they-they'd been caught in affairs and, ya u know, and, uh, had a fall from grace and all this sort of-- And-and taking note, uh, for a good long while because it-it-- I realized, ya know, they weren't bad people. They'd started out good. They just either got imbalanced or, ya know, they succumbed to these temptations. Annd, um, and realizing, not just in-in that category, but in others that "Gosh, I'm-I'm human too."

RES: [long pause] Mm-hmm.

Jonah: And, um, was, uh, ended up being a-a pretty-- A-and I'm in need of God's grace and connection with God daily. I dare not go it alone. Uh, so it ended up being, um, a healing experience in the sense that it gave me a-a truer and more accurate experience of just what it means to be a human being.

RES (Q8): Uh uh, okay, now for yourself on a day-to-day basis how do you deal with, um, depression or other mental health symptoms?

HEZEKIAH: Um…yeah, so um, on a good day- I am AWARE of where-of how I'm doing, and the first thing is, uh, I have a list of-of guys in my life who are pastors of other churches, um, so-they-they're lead pastors. Like-Like, I-I, man I don't mean any disrespect for-towards-towards staff…pastors. There is a different—

RES: (interrupting) yeah there's a different responsibility?

HEZEKIAH: BOND between lead pastors, there's a different level therefore, in formability, cause the-there is a different bond. So, we, um, "We have a shorthand," is what my best friend says, uh, we have a shorthand, we can-we understand each other.

So, uh I have a group of those guys that I'm daily, we're daily in touch and when it's a dark day I'm gonna speak that out. Um, and every person who does daily life with me knows, they've been told, they always have the freedom to sit down in front of me and look me in the eye and then ask me how I'm doing. And they also have the freedom to not believe my answer and to ask more questions, and-and that's reciprocal.

Um and so that-that living in daily awareness AND openness, um, to be questioned, um and-and to be accountable, um, and-and we lovingly confront one another when we see whispers of, "Are you doing this for the praise of man, are you do-are you feeding the drug?" Ya know, um, and so yeah living in, LIVING AS A SHEEP, that's-that's the short hand answer to your question.

Uh, my daily routine in battling depression is living like I'm a sheep who struggles with depression. I'm not the Great Sheppard.

RES (Q9): And what do you think about your future?

JOSEPH: I'm excited, I'm real excited about the future um. I have (long pause) I'm satisfied in-in I can find satisfaction in life, today, um I still have a motivation to continue to accomplish all that the Lord wants to do through my life.

But I can truly find satisfaction in the-in the moments of today…taking my kids swimming yesterday, I found satisfaction in that, um, because th-I'm the only one that can do that. And so it's really just taking the little things in life and making them a big deal, because THEY ARE A BIG DEAL, quite honestly, they really are.

RES: Uh hu, and you mentioned saying are-you-your finding satisfaction in most things now, what was the difference, ya know, during the episode?

JOSEPH: Well, in the moment it's-I call it the- 'the ministry of presence'…being present in the moment that you are. As opposed to having my mind wondering about, 'well I should be doing this, and why didn't do that, OH MY GOSH I forgot to do these types of things.' It's entrusting it to the Lord and being present in the moment.

Um, THAT'S A HUGE DEAL, especially in ministry because…your job is, as I mentioned before, it-your job is "NEVER over", you'll never reach a point where the wall is complete, if you will. And so, there's ALWAYS something to do, there's ALWAYS a phone call that I could make, ya know, ALWAYS.

But, when I'm practicin' the ministry of presence, when I'm FULLY engaged, that's where I find satisfaction.

RES: Uh hu and do-and what are your thoughts, then during the episode you thought?

JOSEPH: So, during the episode, it was-it was, I was always looking for the next thing to do. EVEN IF I WAS in your presence, like this right now, I'd be thinkin about "Oh my gosh, I've gotta fix the backdoor at our house." But I'm not think—ya know what I mean, I do, but I wasn't thinking [chuckles] that in the midst of-in the midst of this conversation because I'm with you.

And that's the difference between the two.

RES: Uh hu, and-What ABOUT that difference?

JOSEPH: So, the difference is, um, the ability to-to celebrate life. To celebrate the little things in life. Prior when I went through my episode, ah…I WAS NOT ABLE TO CELEBRATE. I might give you the IMPRESSION, that I was, cause I could put on a 'game-face' and do 'church' really-really well, um, but I wasn't celebrating internally.

There was still this idea that-ah there's SO MUCH goin on in here that, um…that I'm dissatisfied. I'm really dissatisfied.

RES: And it seemed like a raging storm inside?

JOSEPH: ALWAYS-it's just like that train on the track, ya know it's comin' you just don't know when it's gonna hit you. I don't feel that way anymore. I just, I don't.

RES: Wonderful, wonderful, we're almost done—

JOSEPH: I stepped off the tracks (chuckling) basically so—

RES (Q10): Uh uh, and umm what- ya know, when it comes to this, ya know, what do think pastors who are suicidal and depressed, what do you think they should do?

ISAAC: That's a great question, uuuum (long pause) I mean it seems trite to just say, 'gather good people around you.' Uuum, I think…like we kinda talked about at the very first part, uum, I think mental health has become something that is more talked about now, and I think that's the right move.

Umm, I still think in churches we're behind on…talking about it, uh and then sometimes when you're a pastor, it's kind of "taboo" to-to have real human issues. So hopefully, pastors who are experiencing those thoughts have a space in their…workplace, uum, maybe their supervisor or somebody on staff where they can talk to about that.

Uuum, I feel like I have the-the trust and confidence of people around me in my workplace that I could, uum, I'm not sure if that's everywhere though.

So, my-my hope my answer would beee, ya know, hopefully they're-they can go talk to people about it, if not, hopefully they can find a counselor, right, uum, if-if nothing else, hopefully they can gather…good people around them that they can open to, um, even-even if it is just friends at first, uum, but that will help them find the help that they need.

Again, that seems kind of trite to say, but uuuh-uh, that's kinda-that's the answer that I have, I think.

RES (Q11): Okay. And we're almost done. Now, could you describe how your-- I think you've kind of **[unintelligible 00:42:14]**, how your current church helps you?

PAUL: Yeah. So, um, uh, our board has come alongside, um, me really, really well. Um, and they asked me probably-- We have a monthly meeting and so it's kind of part of the re- regular rhythm now. They wanna report on how I'm feeling, how I'm doing, how our restructure plan has worked, and if it's helping me. Um, like I said, I restructured our staff and so, uh, I feel like I have a lot more support on a day-to-day basis now.

And so, um, they will ask me from time to time how are you doing. Of course, my wife asked me regularly, uh, how I'm doing. And if I tell her the answer that is not the true answer, she'll say, "No, really, uh, how are you doing?" And so, I think that my willingness to kind of involve people has allowed, um, given them permission to check in on me, which has been really good for me.

RES: Mm-hmm. Okay. Now, just-- I mean, so what I'm finding in this is us versus them but your church as a whole, including the congregation, how does your church-- You know, are they receptive, are they not receptive? Like how does your church address mental illness?

PAUL: Um, I would say that we-- So my church does not- they would not even know that, uh, any of this is going on, um, or has gone on in my life because, um, it's just too- it's not something that I've talked about from the stage. And it's our leadership and our, um, governing board that has really been the ones who've l- who've l-I have allowed to kind of come in and-and walk with me through that. But our church in-in general has, um, uh, we're very compassionate towards those, um, um, struggling with mental illness from the standpoint of, um, we have our own counseling center a-as church. And that's something that we created because, um, we are- we recognize that people are broken.

Um, we say all the time that it's okay to not be okay, but it's not okay to stay that way. And so we have ministries like Region, um, where we help walk people through whether they're struggling from addictions or just struggling with emotional, um, challenges, or anger issues or whatever. Um, grief share and all of these care ministries that we provide, um, grief share for, uh, for children and for teenagers. Um, divorce care even for-for teenagers to-to process their emotions as their parents are getting divorced. So, these are the ways that we as a

church are, um, really trying to come alongside of something that's a very real issue for people today and recognize it and then respond to it to the best of our ability.

RES (Q12): Should be through and this final one, you kind of answered this one too. Is, could you describe the quality of your current relationships?

RACHEL: The quality of just any relationship?

RES: Yeah, family friends.

RACHEL: Uh, well, um, uh, you know, great from the family perspective, my husband and I actually really benefited from the time at home during the pandemic as hurt, because all that was like, we felt like our family time was really special and valuable. Um, as far as a church, it's-it's hard to know the further I get in church leadership, the less friends I seem to have at my church and so I'm struggling with that a little bit. I think it's the nature of leading, especially through like a hard season. Um.

RES: What do you think of- what do you think of, I mean, the higher you go up, the more separated you get from-- What do you think about that? Like what do you think is the cause of it?

RACHEL: Um-um, then the-the it's like, I know so much to the, I can't, so the need to always filter, I think is hard um, because there's so much that I know behind the scenes that I can't share and be honest with like my friends who are at the church. Um, and then in the last year we've had a lot to more related to our lead pastor and like his wife and my proximity to them, I think has made me like a lot of people just won't come to me anymore. They won't talk to me because they think I'm on his team. There's-there's yeah.

RES: Mm.

RACHEL: We've quite been in a division. Um, you know, and it's just, I don't know, I've been talking to other leaders, and they've been saying the same thing where they feel like their closest friends are not friends at their church. Um, and that's another thing that I'm really grieving because I'm like, okay, so everyone else at church gets to have their close friends at church.

And we don't, and it's not an exact rule, but it seems to be playing out that like when there's, um, hurt or conflict or anything like the fact that you're on staff automatically, like, I don't know, it's separates you out. So, I'm having a hard time with that. I'm not really sure what to do with that. With yeah-yeah. I'm not sure what to do that.

APPENDIX D
RECRUITMENT LETTER

I humbly ask if you will join my study on American Christian Pastors who have had struggles with mental illness

Dear [Recipient]:

As a graduate student in the Department of Community Care and Counseling at Liberty University, I am conducting research as part of the requirements for a Doctor of Education degree. The purpose of my research is to explore the experience of American church leaders with mental illness and how they deal with it, and I am writing to invite eligible participants to join my study.

Participants must:

- Be 25 years of age or older.
- Be an active Christian leader- pastor, reverend, minister, priest, clergy, or pastoral counselor.
- Have had depression or other emotional or mental problems for over a 2-week span during their time as a church leader.
- Live within 50 miles of Dallas, Texas

Participants, if willing, will be asked to participate in one confidential interview in-person or via an online platform. The first interview should take approximately 60 to 90 minutes. Participants will need to complete a demographics survey at least one week prior to the first interview. Names and other identifying information will be requested as part of this study, but the information will remain confidential.

In order to participate, first complete the screening questionnaire by clicking here to access the survey. You may also contact ….for more information/to schedule an interview.

If you are eligible based on your responses to the screening questionnaire, I will contact you to confirm your willingness to participate and send you a consent document to sign via the secure DocuSign platform; the consent form needs to be completed within a week before the first interview (the consent form can be reviewed at the survey link website).

Participants will receive a $50 visa gift card for completing the interview.

Sincerely,

Erica E. Harris
Graduate Student

APPENDIX E
RECRUITMENT FLYER

Depressed, Anxious, or Distressed?

You are not alone.

Christian church leaders have many responsibilities and other commitments and over time their lives can become overwhelming to the point they develop mental problems. According to research, a number of pastors struggle silently with emotional issues and some suffer serious consequences.

Mental Illness is not a respecter of persons, it can be an issue regardless of faith, ethnicity, gender, age, and or economic standing.

The purpose of this study is to better understand the experience of church leaders with mental problems and how they deal with them with the hope of discovering better ways to help.

Participants will be asked to participate in:

- First interview that should last 60 to 90 minutes
- Second follow-up interview that should last 30 to 45 minutes

Interviews may be in-person or via Zoom©

Eligibility criteria for the study:

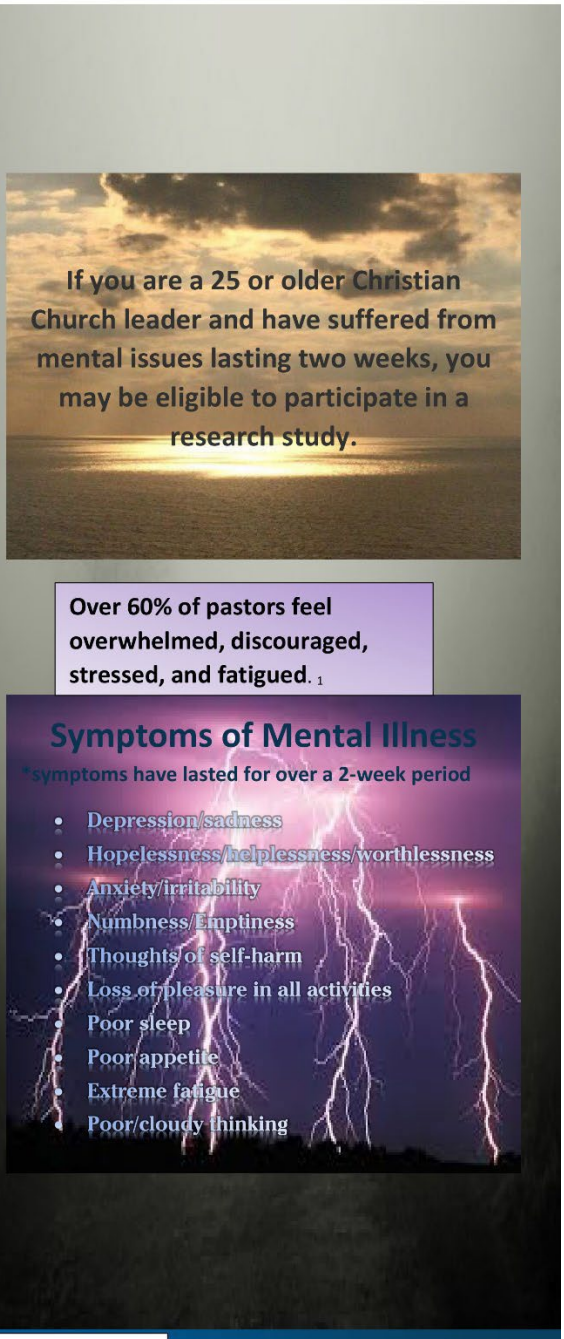
- 25 years of older
- Active Christian church leader: Pastor, Minister, Clergy, Reverend, Priest, or Pastoral Counselor
- Have experienced a mental problem that lasted at least two weeks
- Be willing to participate in two interviews

Participants will receive:

- A $50 visa gift card for completing both interviews.

If you're unsure if you meet the requirements, or if you would like to participate, call or email a member of the study team:

Participation is voluntary and confidential.



1. Pastoralcareinc.com/statistics/

LIBERTY UNIVERSITY

APPENDIX F
CONSENT FORM

Title of the Project: American Church Leaders' Response to Mental Illness

Principal Investigator: Erica Harris, LCSW, Doctoral student, 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 25 years of age or older, an active Christian Church leader regardless of denomination or non-denomination, have had depression or other mental problems for over a 2-week time period, and be willing to take part in one interview. 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 explore how pastors are dealing with mental illness.

What will happen if you take part in this study?

If you agree to be in this study, you are asked to do the following:

1. Participants will complete a screening form and provide descriptive/demographic information. (10 minutes)
2. Participate in the interview which should last between 60 to 90 minutes. The interview may be in-person or via an online/virtual platform. The participants will be recorded by audiotape recorder or through the online/virtual platform.
3. After the interview, participants will receive a follow-up call or email.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study. Benefits to society include decrease in pastoral burnout, severe mental illness, and suicidal tendencies.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life. However, participation in this research has the potential to cause psychological harm in the form of undesired changes in thought processes and emotions, and these changes may be transitory, recurrent, or permanent. The researcher will terminate the interview if a participant appears to be in distress or verbalizes that they are severely distressed and or suicidal, and the researcher will provide appropriate referral resources or connect with the national suicide hotline.

How will personal information be protected?

The records of this study will be kept private. Your responses will be kept confidential, and although your responses will not be associated to your name, I may include quotes from the recording. Published reports will not include any information that will make it possible to identify a subject. All identifying characteristics such as name, address, occupation, city, and ethnic background will be changed. Research records will be stored securely, in password protected files, and only the researcher will have access to the records. Data collected from you may be shared for use in future research studies or with other researchers. If data collected from you is shared, any information that could identify you, if applicable, will be removed before the data is shared.

- Participant responses will be kept confidential through the use of pseudonyms. Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.
- Interviews will be recorded and transcribed. Recordings will be stored on a password locked computer for three years and then erased. Only the researcher will have access to these recordings.

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

Participants will be compensated for participating in this study. Participants will be compensated with a $50 visa e-gift card within 2-weeks after the interview. If participants do not participate in the interview, they will not be eligible for the compensation.

Is study participation voluntary?

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

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

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, 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 Erica Harris. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at

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

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact my supervisor Dr. Penny Boone by phone or by email at Or, you can contact the Institutional

Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515, or email at irb@liberty.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/video-record me as part of my participation in this study.

Printed Subject Name _____ Signature & Date _____

APPENDIX G
PARTICIPANT SCREENING FORM

Participant Screening Form

Please answer the following screening questions. If you answer *Yes* to questions 1, 2, and 3, then proceed with the rest of this questionnaire. If you answer *No* to any of the first three questions, you are not eligible to participate in the study, and there is no need to proceed with the rest of the questions, and you may discard the questionnaire.

Please provide your contact information*.

Name: _____

Cell phone Number:_____

Email: _____

1. Are you 25 years or older? _____Yes_____No

2. Are you a currently employed Christian pastor, clergy, minister, priest, or reverend?____Yes__No?

3. Have you experienced a mental health episode that lasted over 2-weeks during the time you have been a church leader? _____Yes_____No

4. Answer yes or no to the following questions:

- Have you been a very nervous person?_____Yes_____No
- Have you felt so down in the dumps that nothing could cheer you up?_____Yes_____No
- Have you felt calm and peaceful?_____Yes_____No
- Have you felt downhearted and low?_____Yes_____No
- Have you been a happy person? _____Yes_____No

*Your contact information will not be shared or disclosed.

If you meet the criteria, and are selected and agree to participate, a consent form providing information to help you understand what the study is about will need to be completed prior to the interview. The consent form will be emailed to the participant and will need to be signed and returned via email prior to the interview. Alternatively, participants can view and download a copy of the form by going to

APPENDIX H
DEMOGRAPHICS FORM

Participant Demographics Form

Please answer the following screening questions:

1. Age:

25-35 years old

35-44 years old

45-54 years old

55-64 years old

65-74 years old

75 years or older

2. Marital status:

Single, never married

Married or domestic partnership

Widowed

Divorced

Separated

3. Support system:

☐ Spouse or Significant Other

☐ Other family members

☐ Friends

☐ Church congregation

☐ Other pastors/church leaders

☐ Therapist/doctor or another type of medical or psychiatric professional

☐ Other non-licensed professionals such as a life coach.

☐ None

4. Ethnicity

White

Hispanic or Latino

Black or African American

Native American or American Indian

Asian/Pacific Islander

Bi-racial

Other

5. Religious affiliation:

Baptist

Lutheran

Protestant/Evangelical

Presbyterian

Methodist

Church of Christ

Non-denominational

Other

6. Leadership title:

Pastor

Reverend

Bishop

Minister

Clergy

Pastoral Counselor

7. Years in service:

8. Education:

Doctorate

Master's

Bachelor's

Associate

Professional degree

Vocational/Seminary

9. Gender

Male

Female

Prefer not to answer

10. Location:

11. Ministry training:

12. Salary

less than $26, 000

$26,000 to $37,000

$37,001 to $47,000

$47,001 to 57,000

$57,001 to 67,000

$67,001 to $77,000

Above $77,000

This form will be completed via an online survey or emailed as an attachment along with the consent form to participants.

APPENDIX I
INTERVIEW QUESTIONS

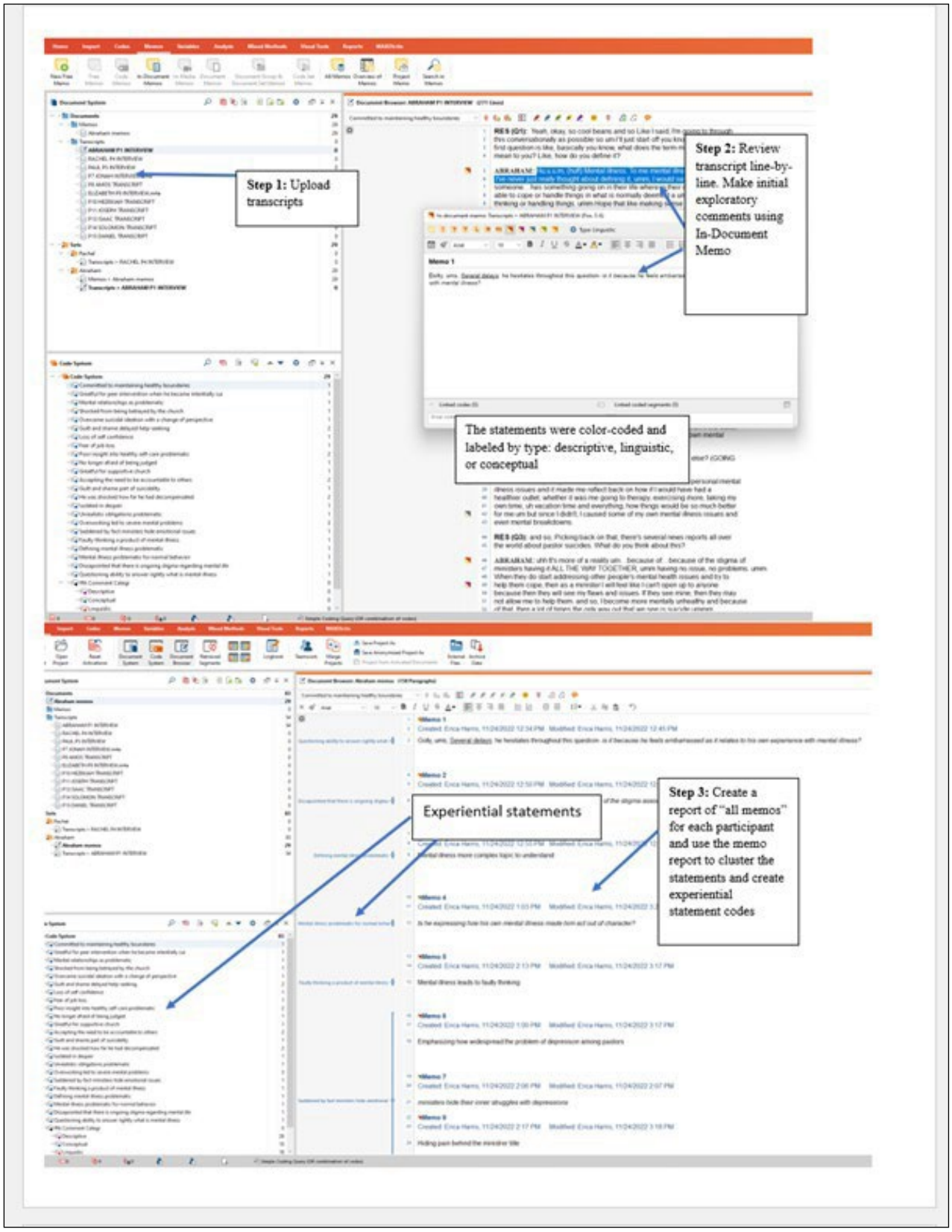
Interview Questions

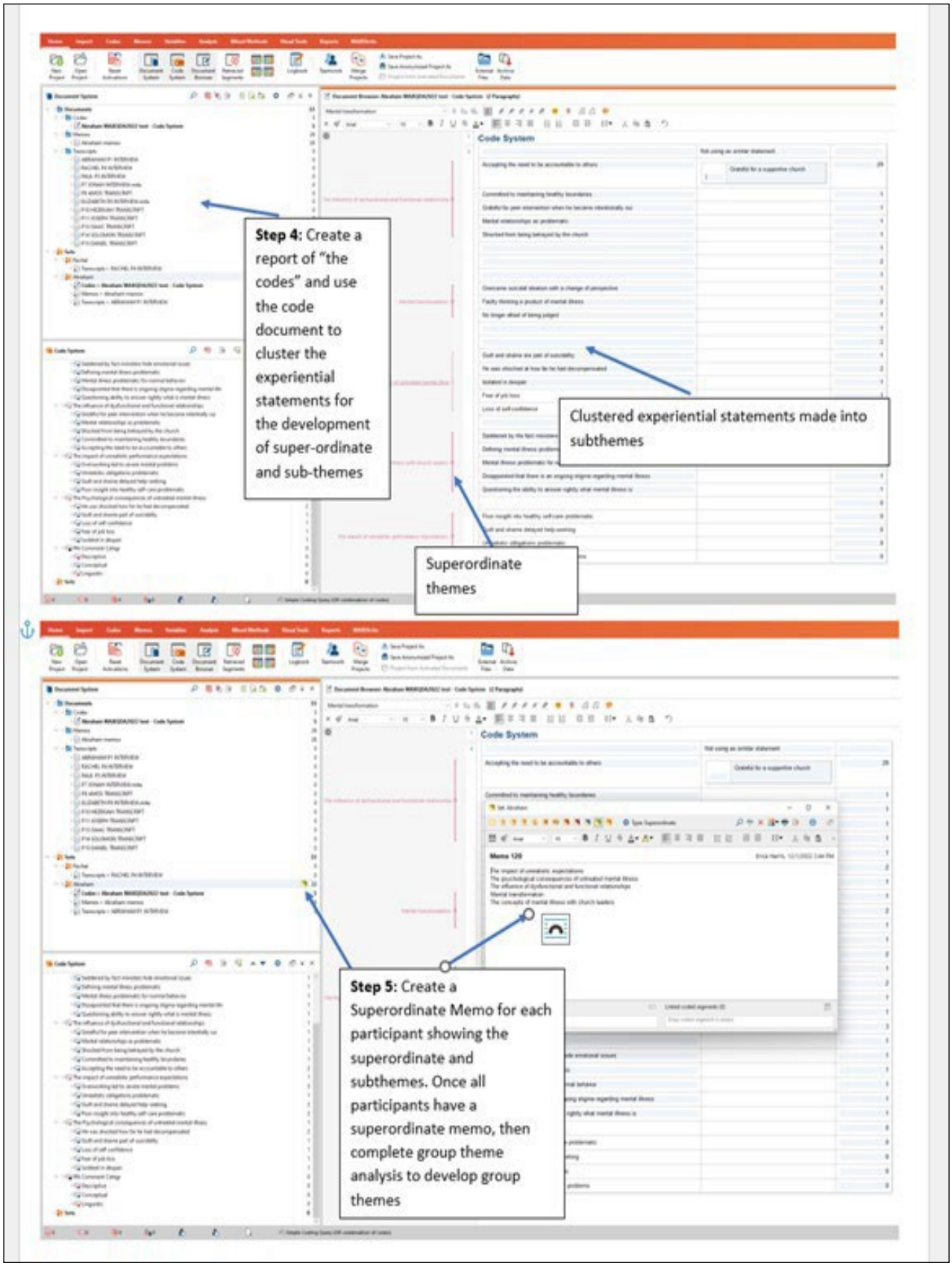
Standardized Open-Ended Semi-Structured Interview Questions

Demographic information includes age, marital status, support system, ethnicity, denomination, leadership title, years in service, education, gender, location, ministry training, and salary. The standardized open-ended semi-structured interview questions are:

1. What does the term *mental illness* mean to you? How do you define it?
2. How much do you think about your mental health?
3. Do you see yourself as being mentally ill? Prompt: always, sometimes? Would you say you are a depressed or anxious person?
4. On a day-to-day basis, how do you deal with depression or other mental symptoms? Prompt, do you have particular strategies for helping yourself or ways of coping, practical, or mental?
5. What do you think contributed to your mental health symptoms?
6. What do you think about your future?
7. Experts report that church leaders are stressed, and many have emotional problems such as depression and anxiety. What do you think about this?
8. There are several news reports all over the world of pastor suicides; what do you think about this?
9. Research indicates that some church leaders are depressed and even have thoughts of suicide. Have you ever had thoughts of suicide since becoming a leader in the church? If so, what contributed to these thoughts, and what did you do about them?
10. What do you think pastors who are depressed or suicidal should do about it?
11. Could you describe how your current church helps you?
12. Could you describe the quality of your relationships?

APPENDIX J
SAMPLE THEME DEVELOPMENT- MAXQDA




Code System
Step 4: Create a report of "the codes" and use the code document to cluster the experiential statements for the development of super-ordinate and sub-themes
Clustered experiential statements made into subthemes
Superordinate themes
Code System
Step 5: Create a Superordinate Memo for each participant showing the superordinate and subthemes. Once all participants have a superordinate memo, then complete group theme analysis to develop group themes

APPENDIX K
The Mental Health Inventory - 5 (MHI-5)

Instructions:

Please read each question and tick the box by the **ONE** statement that best describes how things have been FOR YOU during the past month.

There are no right or wrong answers.

1. During the past month, how much of the time were you a happy person?

All of the time	Some of the time
Most of the time	A little of the time
A good bit of the time	None of the time

2. How much of the time, during the past month, have you felt calm and peaceful?

All of the time	Some of the time
Most of the time	A little of the time
A good bit of the time	None of the time

3. How much of the time, during the past month, have you been a very nervous person?

All of the time	Some of the time
Most of the time	A little of the time
A good bit of the time	None of the time

4. How much of the time, during the past month, have you felt downhearted and blue?

All of the time	Some of the time
Most of the time	A little of the time
A good bit of the time	None of the time

5. How much of the time, during the past month, have you felt so down in the dumps that nothing could cheer you up?

All of the time	Some of the time
Most of the time	A little of the time
A good bit of the time	None of the time

APPENDIX L

THE MHI-5 PERMISSION EMAIL

[External] RE: Confirmation no permission is needed to use and reproduce the MHI-5

Ingrid Maples
Mon 10/31/2022 12:01 PM

To: Harris, Erica RANDHealthCare <RANDHealthCare@rand.org>

Dear Ms. Harris - Thank you for your email. All of the surveys and tools are located on our website.

They are public documents, available without charge. Please provide an appropriate citation when using these products. No further permissions are needed.

Thank you for your interest in RAND Health Care. Good luck with your research.

Sincerely,

Ingrid Montemayor-Maples

Ingrid Montemayor-
Maples RAND Health
Care

RAND
Corporation
1776 Main St

Santa Monica, CA 90407-

imaples@rand.org
http://www.rand.org/health/
RAND Health Care on Twie
er

From: Harris, Erica

Sent: Monday, October 31, 2022, 8:47 AM

To: RANDHealthCare <RANDHealthCare@rand.org>

Subject: [EXT] Confirmation no permission needed to use and reproduce the MHI-5

Greetings, I am a doctoral student at Liberty University completing a dissertation in Community Care and Counseling. I am writing to ask written permission to use the abbreviated version of the Mental Health Inventory, the MHI-5, in my research study. I am researching pastors who have experienced mental illness. My research is being supervised by my chair, Dr. Penny Boone.

I am only using the survey as a way to determine what participants to include in the study. I am not altering the survey. I plan to use the survey to exclude participants whose test results indicate they are

dealing with an active mental health episode. The potential participants will complete the survey as part of the recruitment process.

In addition to using the instrument, I also ask your permission to reproduce it in my dissertation appendix. The dissertation will be published at the Jerry Falwell Library (JFL) and deposited in the ProQuest Dissertations & Theses database.

I would like to use and reproduce your MHI-5 under the following conditions:

- I will use the MHI-5 only for my research study and will not sell or use it for any other purposes
- I will include a statement of attribution and copyright on all copies of the instrument. If you have a specific statement of attribution that you would like for me to include, please provide it in your response.
- At your request, I will send a copy of my completed research study to you upon completion of the study and/or provide a hyperlink to the final manuscript

If you do not control the copyright for these materials, I would appreciate any information you can provide concerning the proper person or organization I should contact.

If I do not need any permission to use and reproduce the MHI-5, please reply back confirming this.

If these are acceptable terms and conditions, please indicate so by replying to me through e- mail at

Sincerely,

Erica

Harris

This permission letter has been adapted with permission from:

- Appendix E of the Senior Thesis Handbook (2009-2010), Psychology Department, Dominican University of California Simon, M. K. (2011).
- Dissertation and scholarly research: Recipes for success (2011 Ed.). Seattle, WA, Dissertation Success, LLC. http://dissertationrecipes.com/wp-content/uploads/2011/04/Permissions.pdf

Erica E. Harris, LCSW, Liberty University Doctoral Student

APPENDIX M

THE GOTRANSCIPT HIPAA STATEMENT

Transcription

GoTranscript Achieves HIPAA Compliance with Compliancy Group

GoTranscript is pleased to announce that it has taken all necessary steps to prove its good faith effort to achieve compliance with the Health Insurance Portability and Accountability Act (HIPAA). Through the use of Compliancy Group's proprietary HIPAA solution, The Guard™. GoTranscript can track their compliance program and has earned their Seal of Compliance™. The Seal of Compliance is issued to organizations that have implemented an effective HIPAA compliance program through the use of The Guard.

HIPAA is made up of a set of regulatory standards governing the security, privacy, and integrity of sensitive healthcare data called protected health information (PHI). PHI is any individually identifiable

healthcare-related information. If vendors who service healthcare clients come into contact with PHI in any way, those vendors must be HIPAA compliant.

GoTranscript has completed Compliancy Group's Implementation Program, adhering to the necessary regulatory standards outlined in the HIPAA Privacy Rule, Security Rule, Breach Notification Rule, Omnibus Rule, and HITECH. Compliancy Group has verified GoTranscript's good faith effort to achieve HIPAA compliance through The Guard.

Clients and patients are becoming more aware of HIPAA compliance requirements and how the regulation protects their personal information. Forward-thinking providers like GoTranscript choose the Seal of Compliance to differentiate their services.

Security, privacy, and confidentiality guarantee: 2048-bit SSL encryption, NDA protection

APPENDIX N

THE DOCUSIGN TRUST BRIEF

DocuSign Trust Brief

World-class protection

DocuSign has implemented rigorous policies, processes and training to meet the privacy, security and compliance requirements of some of the most stringent certifications around the world.

Privacy

We secure and protect not only your agreements but also the critical business and personal information that you entrust to us.

Confidentiality: DocuSign manages customer data as a data processor on the customer's behalf and in accordance with their informed consent. We use and access customer data only to the extent necessary to perform services, and we require all third-party subprocessors to adhere to the same privacy and security obligations as DocuSign.

Privacy rights: We recognize the privacy rights of our prospects, customers and partners and comply with global privacy regulations, including the European Union's **General Data Protection Regulation** (GDPR), the California Consumer Privacy Act (CCPA) and other privacy laws and regulations based on same privacy principles as GDPR.

Privacy management: We continually review rapidly evolving global privacy requirements to enhance and evolve DocuSign's data protection program. We also perform regular internal audits of our privacy practices and require mandatory privacy training by all DocuSign personnel.

Security

We make significant investments in our security and operations and maintain a comprehensive and robust approach across our platform, processes and people.

Platform: DocuSign's advanced platform architecture and security operations are designed to maximize security for data at rest and in transit, and each component of our trusted platform undergoes stringent security review.

- Geo-diverse, ISO-certified, SOC-audited data centers
- 24/7/365 onsite security
- Endpoint security
- AES 256-bit encryption (at rest)
- PKI technology
- Malware protection

World-class protection
Strong security mechanisms and robust operational processes allow us to meet or exceed the highest international security standards and protect your documents and data.

Global reach and acceptance
DocuSign eSignature is lawful in most civil and common law jurisdictions for most agreement types and employed by hundreds of millions of users worldwide, including the European Union.

High availability
A robust infrastructure delivering consistent high availability provides assurance that our service is there whenever you need it.

Risk management

DocuSign maintains a risk management framework to help identify, manage and mitigate information security risks. We meet or exceed national and international standards while maintaining strict policies and practices that set the standard for world-class risk management.

Enterprise risk management: DocuSign has adopted a holistic, enterprise-wide approach to risk management. We continually identify, assess and analyze key conditions and events in terms of likelihood and magnitude of impact to our business. This comprehensive monitoring process is complemented by an in-depth response strategy.

DocuSign Control Framework (DCF): The DCF is a comprehensive matrix that tracks control activities across DocuSign's entire eSignature platform and operations and is designed to ensure mapping and adherence to applicable industry standards.

Internal audits: Internal audit teams continually review security and operational processes.

Compliance certifications

In addition to internal audits, DocuSign also undergoes regular external audits to maintain globally recognized certifications and attestations, including:

SOC 1 Type 2 and SOC 2 Type 2
As a SOC 1 and SOC 2-certified organization, DocuSign undergoes annual examination and testing. The resulting external audit reports attest to the design and operating effectiveness of internal controls across our business, including security, availability, processing integrity and confidentiality.

ISO 27001: 2013
The highest level of global information security assurance available today, ISO 27001 provides customers assurance that DocuSign meets stringent international standards on security.

PCI DSS
DocuSign maintains compliance with the current version of the Payment Card Industry Data Security Standard (PCI DSS) to ensure safe and secure handling of credit card holder information.

For a full list of our certifications and geographical recognition, visit the **Compliance page on the DocuSign Trust Center**.