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Apostolic Pentecostal Clergy Beliefs Regarding Mental Health Disorders

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Apostolic Pentecostal Clergy Beliefs Regarding Mental Health Disorders

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Abstract

A core competency of counselors is to embrace client diversity and practice in a culturally appropriate manner. It is important to recognize clients’ unique cultural contexts and the resulting “lens” in which they view the world. This shared “lens” of perception includes how people define illness, including mental health disorders and the perceived causes, as well as the accepted modalities of treatments. This is true with individuals from various religious cultures. Religion can be a potent web of influence and can create shared meanings that shape worldviews.

This is true of Pentecostals who espouse a specific worldview that lends itself to a unique cultural lens of understanding mental health disorders. Their worldview is complex and embraces the natural realm while highly valuing the spiritual realm. They believe that the Holy Spirit is an active integral part of their lives. As such, they believe that divine healing from illness is attainable if God wills it so. These beliefs in the supernatural, as well as ways they are lived out, are important to consider when discussing views regarding their beliefs regarding causes and treatments of mental health disorders. They also highly value the role of the clergy and often turn to them for help with mental health problems.

The goal of this study was to explore the Apostolic Pentecostal clergy’s beliefs regarding mental health disorders within the context of their unique spiritual worldview. Seven Apostolic Pentecostal clergy were interviewed via a semi-structured telephone interview.

The results found that Apostolic Pentecostal clergy viewed biological and psychosocial determinants as causes of mental health disorders. They endorsed professional counseling and medication with concurrent pastoral care to address the whole person. Treatment was viewed in
the context of healing. They believed that God could heal any problem instantly, or in a gradual healing process that incorporates the clergy and counselors working together with the help of the Holy Spirit. The clergy saw their role as providing spiritual care while supporting parishioners as they received concurrent mental health care. Clergy embraced collaboration with counselors, with a preference for counselors who believed in God. Clergy reported that negating the importance of the spiritual realm or going against their faith-based practices would create problems for them, as well as their parishioners.

Clergy indicated that it was important for counselors to know that Apostolic Pentecostals operate within a strong faith-based worldview. In addition, they wanted counselors to know that they embrace education and outside help in addition to the working of the Holy Spirit and pastoral care in treating mental health disorders. However, their parishioners may have difficulty asking for help based on past teaching that asserted that if one had God’s Spirit, they would not need outside help.

The results indicate that the Apostolic Pentecostal clergy held shared beliefs regarding causes and treatments of mental health disorders, as well as those they trusted to address these issues. In addition, the results display significant differences from past research with Pentecostals. Implications for counseling and future research are discussed.
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2.1 Participant Profile
Chapter One-Introduction and Literature Review

A core competency of counselors is to embrace client diversity and practice in a culturally appropriate manner. The American Counseling Association defines this *multicultural/diversity competence* as “a capacity whereby counselors possess cultural and diversity awareness and knowledge about self and others, and how this awareness and knowledge is applied effectively in practice with clients and client groups” (2005, p. 20). The American Counseling Association confirms the importance of this competency in its Professional Code of Ethics Preamble: “Association members recognize diversity and embrace a cross-cultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts” (2005, p. 3). This competency of practicing counseling within a multicultural framework is specified throughout the American Counseling Association’s Professional Code of Ethics in the areas of the counseling relationship, confidentiality and privacy, professional responsibility, relationships with other professionals, evaluation and assessment, supervision and training, and research and publication (ACA, 2005).

The American Counseling Association (2005) recommends counselors to practice within a framework of *Multicultural/Diversity counseling* that “recognizes diversity and embraces approaches that support the worth, dignity, potential, and uniqueness of individuals within their historical, cultural, economic, political, and psychosocial contexts” (p. 20). Sue and Sue (2003) advocate for the practice of *multicultural counseling/therapy* as:

- both a helping role and process that uses modalities and defines goals consistent with the life experiences and cultural values of clients, recognizes client identities to include individual, group, and universal dimensions, advocates the use of universal and culture-specific strategies and roles in the healing process, and balances the importance of
individualism and collectivism in the assessment, diagnosis, and treatment of client and client systems. (p. 16)

Sue and Sue (2003) assert that counselors must embrace a “holistic approach to understanding personal identity” that recognizes all three levels of human existence: individual, group, and universal (p. 14). They explain this as a “tripartite framework for understanding the multiple dimensions” of human identity (p. 10) and offer this ancient Asian quote: “All individuals, in many respects, are (a) like no other individuals, (b) like some individuals, and (c) like all other individuals” (p. 11). First, “all individuals are, in some respects like no other individuals” (p. 12). All of us are unique in our biological makeup, psychological nature, and our experiences. No two individuals are alike. Second, “all individuals are, in some respects, like some other individuals” (p. 13). Individuals are a part of a group identity which includes ethnicity, culture, disability/ability, age, socioeconomic status, gender, race, sexual orientation, marital status, and religious preference. Third; “all individuals are, in some respects, like all other individuals” (p. 13). Individuals share a universal dimension of identity. All are apart of the human race and share some commonalities. Humans share biological and physical similarities, self-awareness, common life experiences, and the ability to use symbols. Sue and Sue also assert that often, counselors acknowledge the individual and universal dimensions of human identity, but fail to account for the group identity of people. This research focuses on one aspect of client group identity, specifically beliefs regarding mental health disorders within the context of the culture of religion.

Culture, that is, “the customary beliefs, social forms, and material traits of a racial, religious, or social group; also: the characteristic features of everyday existence…shared by people in a place or time” (culture, 2012), influences how people think, make decisions, behave,
and define events (Sue & Sue, 2003). This is true regarding beliefs of the causes of mental health disorders, as well as treatments (Brown, 1995; Furnham & Chan, 2004; Furnham & Malik, 1994; Furnham & Henley, 1988; Sue & Sue, 2003; Sussman, 2008). Each cultural group “may have its own distinct interpretation of reality and offer a different perspective on the nature of people, the origin of disorders, standards for judging normality and abnormality, and therapeutic approaches” (Sue & Sue, 2003, p. 15). The American Counseling Association concurs “that culture affects the manner in which clients’ problems are defined” (2005, p. 12) and Olafsdottir and Pescosolido (2009) assert, “Individuals experiencing mental health problems are embedded in cultural systems that harbor beliefs, opinions, and attitudes about mental health as well as the utility of different treatment options” (p. 229).

Sussman (2008) confirms that the “cultural lens” in which people view their world affects beliefs and practices related to illness. Sussman quotes C. Helman’s (1994) definition of culture and its emphasis on illness interpretation:

Culture is a set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment … To some extent, culture can be seen as an inherited “lens,” through which the individual perceives and understands the world that he inhabits, and learns how to live within it. Growing up within any society is a form of enculturation, whereby the individual slowly acquires the cultural “lens” of that society. Without such a shared perception of the world, both the cohesion and continuity of any human group would be impossible.
One aspect of this “cultural lens” is the division of the world, and the people within it, into different categories...For example…”kinfolk” or “strangers,” “normal” or “abnormal,” “mad” or “bad,” “healthy or “ill.” And all cultures have elaborate ways of moving people from one social category into another (such as from “ill person” to “healthy person”), and also of confining people—sometimes against their will—to the categories into which they have been put (such as “mad,” “disabled” or “elderly”). (Helmen, 1994, pp. 2-3, as cited in Sussman 2008, p. 38-29)

Sussman (2008) states that this “cultural lens” includes ways people recognize illness, the way it is presented to others, the attributes of those that they present their illness to, and the way they deal with the illness. Members of cultural groups also show “patterns of belief about the causes of illness; norms governing choice and evaluation of treatment; socially-legitimated statuses, roles, power relations, interaction settings, and institutions” (Kleinman, 1980, p. 24). These beliefs and practices have conceptual, personnel, and behavioral components. Conceptual components would include beliefs concerning the cause of an illness, as well as expectations regarding prognosis; personnel components refer to those regarded in the community as trusted healers. And finally, behavioral components constitute the norms when seeking treatment and consulting healers (Sussman, 2008). Regardless of the validity of these beliefs, they will influence decisions about the types of treatment to seek (Harley, 2006).

**Statement of the Problem**

In the past, researchers have focused on the ways that race, socioeconomic status, gender, sexual orientation, and other demographic variables have shaped people’s beliefs and have focused less on the cultural lens of religious affiliation (Francis, 2009; Richards & Bergin, 2000; Schnittker, Freese, & Powell, 2000; Shafranske & Malony, 1996; Sue & Sue, 2003). This
is changing with researchers advocating for counselors to understand the tremendous influence religious affiliation can have on clients’ worldviews and beliefs regarding mental health (Dobbins, 2000; Koller, 1994; Harley, 2006; Richards & Bergin, 2000; Trice, 2003; Shafranske & Malony, 1996; Thompson, 2010). Shafranske and Malony (1996) assert that religious affiliation and spiritual beliefs:

- may be far more potent social glue than the color of one’s skin, cultural heritage, or gender … Religious identification for some may be the thread that unites individuals into a social unit, … religion must be taken account of as a factor in any appreciation of individual difference and cultural diversity. (p. 564)

Richards and Bergin echo this: “There is a great need for mental health professionals to become aware of the religious diversity that exists in the world and increase their competence in working with clients from diverse traditions” (2000, p. xvii). The American Counseling Association (2005) also confirms the importance of religion as a diversity issue by endorsing the fourteen spiritual competencies outlined by the Association for Spiritual, Ethical, and Religious Values in Counseling, one of the American Counseling Association’s divisions. Specifically, the first two competencies entitled “Culture and Worldview” state that “the professional counselor can describe the similarities and differences between spirituality and religion, including the basic beliefs of various spiritual systems, major world religions, agnosticism, and atheism” and can recognize “that the client’s beliefs (or absence of beliefs) about spirituality and/or religion are central to his or her worldview and can influence psychosocial functioning” (Association for Spiritual, Ethical, and Religious Values in Counseling, 2009, p. 1).

Richards and Bergin (2000) confirm the need for competency in religious diversity and give four reasons for mental health counselors to acquire this competency. These include: (a)
“religious diversity is a cultural fact, and most mental health professionals will encounter it in their practices” (p. 5), (b) “psychotherapists will enjoy more credibility and trust with religious clients, leaders, and communities if they obtain training and competency in religious and spiritual diversity (p. 10), (c) “psychotherapists have an ethical obligation to obtain competency in religious and spiritual diversity” (p. 12), and (d) “competency in religious diversity may help psychotherapists understand how to access more fully the healing resources in religious communities to assist their clients in coping, healing, and changing” (p. 13).

Researchers advocate for counselors to understand that religion is an important cultural fact and has a tremendous influence on clients’ worldviews (Dobbins, 2000; Pate & Bondi, 1992; Pincus, 1998; Richards & Bergin, 2000; Shafranske, 1996; Shafranske & Malony, 1996; Sue & Sue, 2003; Weaver, 1998). Shafranske (1996) asserts that the influence of religion cannot be dismissed even for those that are unchurched, atheist, or agnostic. Religion is a “web of significance” provided by culture and constructed by human community. According to Shafranske, religion “forms the creation of a sense of a personal identity and provides a ‘sacred canopy’ under which spheres of relevancy are created that orient human values and ultimately determine behavior” (p. 2). Religion can be a silent thread of influence and coherence in a person’s life that is sometimes almost imperceptible or it can be a clear and potent source of influence (Shafranske, 1996). Weaver (1998) confirms that “religion and spirituality are important factors in the lives of most Americans” (p. 349) and can provide meaning, support, and affiliation. Gallup polls support this and report that 92% of Americans said they believe in God; 55% of Americans said religion is very important in their lives; and another 26% said it is fairly important (Newport, 2011).
As such, individuals from various religious cultures often hold different beliefs regarding the causes and treatment of mental health disorders (Dobbins, 2000; Harley, 2006; Koller, 1994; Richards & Bergin, 2000; Trice, 2003). This has been found to be true for Christians in general (Stanfield, 2002) as well as those of the Pentecostal faith tradition (Harley, 2006; Koller, 1994; Trice, 2003). Pentecostals espouse a specific worldview that lends itself to a unique cultural lens of understanding mental health disorders. Pentecostals place the transforming experience of the Holy Spirit central in their lives. This immediate experience of the Holy Spirit shapes their worldview in a definitive way (Satyavrata, 2006).

Given that Pentecostals put the working of the Holy Spirit in their lives as a primary focus, it is natural that they would highly value the beliefs of their spiritual leaders, their clergy. Also, numerous studies have shown that those with mental illness and social problems are more likely to turn to their clergy than to mental health professionals (Blank, Mahmood, Fox, & Guterbock, 2002; Burgess, 1998; Chalfant, Heller, Roberts, D.Briones, Aguirre-Hochbaum, & Farr, 1990; Franklin & Fong, 2011; Koenig, 2005; Larson, Milano, Weaver, & McCullough, 2000; Pickard & Guo, 2008; Wang, Berglund, & Kessler, 2003). Clergy are among the most trusted professionals in society, are often in long term relationships with individuals and families, assist church members during crises, and can help mental health professionals meet their members’ needs (Weaver, 1998). In addition, clergy members may hold different views regarding mental health (Koller, 1994). Also, researchers (Harley, 2006, Trice, 2003) who have studied Pentecostal beliefs regarding causes and treatments of mental health disorders found that Pentecostals preferred speaking to their clergy over a mental health professional. Koller (1994) and Harley (2006) noted that due to the influence of the clergy on their congregations, investigating the beliefs of the Pentecostal clergy would offer key information for counselors.
working with the ever growing number of Pentecostal clients, as well as those seeking to collaborate with Pentecostal clergy. To date, there has been a paucity of research with Pentecostal clergy.

**Purpose of the Study**

The purpose of this study was to assess the beliefs regarding mental health disorders and the practices of a subgroup of Classical Pentecostal clergy known as “Oneness Pentecostal” or “Apostolic Pentecostal” clergy. There has been a paucity of research with the Oneness Pentecostals (French, 1999). The Oneness Pentecostal group comprises an estimated one fourth of Pentecostals worldwide (Seagraves, 2006) and is a stream of Pentecostalism that, like other Classical Pentecostals, traces its roots back to the Pentecostal revival movement in the early 1900s (Reed, 2002). However, Oneness Pentecostalism is a “theologically distinctive branch of the Pentecostal movement” emphasizing water baptism in the name of Jesus, as well as the “absolute, indivisible ‘Oneness’ of God revealed in the full Deity of Jesus Christ” (French, 1999, p. 15). This study sought to gain an understanding of the Apostolic Pentecostal clergy’s current beliefs regarding the causes and treatment preferences for mental health issues within their congregations and how these beliefs are shaped by their unique worldview. It also sought to assess current counseling practices and endorsed treatments used to meet the mental health needs of church members. As such, this study sought to identify ways that mental health professionals can collaborate with Apostolic Pentecostal clergy to meet the needs of their members.
Research Questions

The study sought to discover the Apostolic Pentecostal clergy beliefs regarding the causes and treatment of mental health disorders. What kind of mental health needs are they seeing in their congregations and how are they meeting those needs? What are the roles of clergy, mental health professionals, and the Holy Spirit in meeting those needs?

Significance of Study

Due to Pentecostals’ unique worldview, they have been the subject of various studies. These have included studies on mental health outcomes (Belcher & Cascio, 2001; Koenig, Ford, George, & Blazer, 1993; Mariz, 1991; Meador, Koenig, Hughes, Blazer, & Turnbakk, 1992; Vega, 2004), coping with illness (Pargament, Poloma, & Tarakeshwar, 2001), the practice of speaking in tongues known as glossolalia (Francis & Kay, 1995; Gritzmaher, Bolton, & Dana, 1988; Lynn, 2009; Proctor, 1990; Seagraves, 2005); prayer practices (Dein & Littlewood, 2007), personalites of Pentecostals (Clark, 1984; Francis & Kay, 1995; Gritzmaher, Bolton, & Dana, 1988), deliverance practices (Belcher & Cascio, 2001; Belcher & Hall, 2001), healing (Poloma & Hoelter, 1988), leadership development (O’Daniel, 2005), authority of women (Casselberry, 2008), and socio-political/cultural values (Dearman, 1974; Lewis, 1986; Martin-Baro, 1990; Robbins, 2004; Tangenberg, 2007). Despite the plethora of studies, only three studies have focused on Pentecostal beliefs regarding causes and treatments of mental illness (Koller, 1994; Harley, 2006; Trice, 2003) and none have focused specifically on the Pentecostal clergy’s beliefs regarding the causes and treatments of mental illness with an in depth exploration of their beliefs of how the Holy Spirit ministers to those with mental illness. Only a few studies have focused on Oneness Pentecostals (e.g., Casselberry, 2008; Lynn, 2009; Seagraves, 2005).
This study explored the Apostolic Pentecostal clergy’s counseling practices and beliefs regarding causes and treatments of mental health disorders. Despite the fact that this group makes up an estimated one fourth of Pentecostals, this subgroup has only been studied by a few researchers (e.g. Casselberry, 2008; Lynn, 2009; Seagraves, 2005) and even fewer have studied Apostolic Pentecostal clergy (O’Daniel, 2005). This research was designed to gain a better understanding of how mental health professionals can collaborate with the Apostolic Pentecostal clergy in order to help meet the mental health counseling needs of their church members. The research sought to contribute to the literature of religious diversity by educating mental health professionals on the unique worldview of Pentecostal clients in order to provide culturally appropriate treatment practices and facilitate collaboration with Pentecostal clergy.

**Literature Review**

This literature review will present information on religion as an important cultural factor, as well as information regarding the Pentecostal worldview. This will be followed with a discussion on the beliefs of the causes and treatments of mental health disorders: first those of the American public; next, those of Christians; followed by those of Pentecostals; and finally, those espoused by clergy.

**Religion.** Religion has been defined in a variety of ways. Merriam Webster defines religion as “the service and worship of God or the supernatural; commitment or devotion to religious faith or observance; a personal set or institutionalized system of religious attitudes, beliefs, and practices” (religion, 2012). Francis (2009) described religion as a social construct that helps to provide boundaries of the belief system it represents, and thus differentiates between different orthodoxies and faith systems. Francis notes that adherents follow a set of
beliefs in both thoughts and actions. Koenig (2008), in defining religion, agrees that it entails beliefs, as well as practices and behaviors, and asserts:

Religion involves beliefs, particularly in God (or ultimate truth/reality), and rules of behavior and practices associated with those beliefs. It has a community orientation, and traditions and rituals are associated with membership. Religion involves carrying out certain personal responsibilities and duties (love of neighbor, care for the needy), as well as avoiding certain behaviors and practices (alcoholism, drug addiction, smoking, sex outside marriage). (p. 54)

Miller and Yamamori (2007) concur that religion involves complex belief systems that are usually associated with “a set of practices or rituals that are enacted within the community of like-minded individuals” (p. 12) and is as much about community as the theological propositions. Miller and Yamamori further state that religion “is the attempt to find purpose and personal significance of an ultimate sort” (p. 12). As such, they assert that religion is irreducible and functional explanations cannot “account for the whole of religion” (p. 13) or help us understand “the role religion plays in human life” (p. 13).

Wulff (1996) asserts that the Western culture’s popular indicators of religion as the “belief in a divine being or power and regular association with a ritual community” (p. 46) has increasingly been found to be inadequate in describing the concept of religion. Wulff describes Smith’s (1963) assertion that the terms “religion” and “religions” have largely “evolved to serve the needs of outsiders” and “are thus inherently misleading…they fail to represent the dynamic personal element in human piety” (p. 46). According to Wulff, Smith proposes the use of the terms cumulative tradition and faith. Cumulative tradition is described as observable contents that are accumulated over time and passed on through generations. These may include
elements such as scriptures, moral codes, social institutions, and myths. Faith is described as “one’s orientation toward self, other people, and the universe as they are experienced in the light of transcendent dimension” (Wulff, 1996, p. 47). For this reason, many people use the terms “spiritual” and “spirituality” instead of “religion.” Although these are often used interchangeably and seen as synonyms, most researchers distinguish between “religion” and “spirituality” (Francis, 2009; Koenig, 2008; Tjeltveit, 2012; Wulff, 1996).

Koenig (2008) sees spirituality as a quest for the sacred that is individual and personal. It is difficult to define and measure. Francis (2009) says that spirituality is how an individual lives out his/her religion in the world and can be understood as a person’s search to find meaning and his/her place. This search may entail a relationship with a divine or transcendent power that can be considered sacred. Webster’s dictionary defines spirituality as “sensitivity or attachment to religious values; the quality or state of being spiritual” (spirituality, 2012) with spiritual being defined as “of relating to, consisting of, or affecting the spirit; of or relating to sacred matters” (spiritual, 2012). Researchers point out that individuals can be religious and not spiritual, spiritual and not religious, or can view themselves as both spiritual and religious (Francis, 2009; Wulff, 1996).

Regardless of how it is defined, religion as a cultural fact must be taken into account if providers are to understand and help fellow human beings (Wulff, 1996). Religion by definition concerns itself with a shared, ultimate reality. 

The psychology of religion. The psychology of religion has been given serious attention by several scholars including G. Stanley Hall, William James, Sigmund Freud, Jean Piaget, Erik Erikson, C. G. Jung, B. F. Skinner, Gordon Allport, Erich Fromm, and Abraham Maslow (Allport, 1950; Erikson, 1963; Frued, 1953; Fromm, 1950; James, 1985; Jung, 1968; Maslow,
1964; Skinner, 1953) In the 1920s, interest in subjective religious experience decreased with the success of behaviorism. It survived as pastoral psychology of religion and the psychoanalytic critique of religion. In 1950, it was revived again after the decline of behaviorism (Wulff, 1996).

Wulff (1996) identified two trends in the psychology of religion: descriptive and explanatory. Descriptive scholars are often religiously committed scholars. They are concerned with documenting different types and varieties of religious experience, often placing significance on age and life stage. Their goals are usually to nourish religious life, often through pastoral care and religious education. Edwin Starbuck, James Pratt, Gordon Allport are given as examples. Explanatory trends, on the other hand, are often promoted by those who are suspicious or disdainful of popular piety. They often seek to find the origins of religious experience and practice in terms of the psychological, biological, and the environmental, rather than in a transcendent realm. The goal is the advancement of knowledge of human behavior and experience. Sigmund Freud, B. F. Skinner, and James Leuba are described as those of this trend. The psychologists of the two trends are likely to conceive of religion in contrasting terms. Descriptive psychologists identify religion with an experiential core: the inner, subjective states of great mystics or subtle transcendental moods of the faithful. Explanatory psychologists usually see piety in external expressions: creeds and rituals.

Religion as a liability. James Leuba (1925, 1950) saw religion as pathological and irrational and believed that mystic experiences could be adequately accounted for by psychology and physiology. He asserted that conservative religious views inhibit the pursuit of scientific knowledge. Despite Leuba’s infamous critiques of religion, Wulff (1996) points out
that Leuba wanted to reform religion, not destroy it, citing that Leuba advocated for modified forms of prayer, ceremony, confession, and sacred art (Wulff, 1996).

B.F. Skinner (1953) described religion as reinforced behavior. According to Skinner, priests or other people in power reinforce religious behavior with reinforcing stimuli for their own personal gain or society. Other behaviors happen by accidental reinforcement, including superstitions that are reinforced by chance. He was critical of religion because of the historical use of negative reinforcement and threats of punishment. On the other hand, he observed that religion was shifting to more positive measures, and may help people delay gratification for a better future (Wulff, 1996).

George Vetter (1958) believed religion was in response to unpredictable situations, but that it had no redeeming value. He pointed to the backward views on social issues by religious leaders, failure of empirical evidence to show religious faith affects moral behavior, and wars committed in the name of religion. He believed that behaviors such as prayer, medication, and ceremony were merely illusions and do not solve problems (Wulff, 1996).

Sigmund Freud, one of the most widely known psychologists, saw religion as infantile wish fulfillment. He believed religion was the combination of infantile or neurotic tendencies. He compared the fervent belief in a father-god and detailed obligatory rituals to obsessive symptoms of neurosis. He believed that religious beliefs and practices have their roots in the universal experiences of childhood. He asserted that longing for a father constitutes the root of every form of religion. According to Freud, in early childhood, the child perceives parents especially his or her father, as omniscient and omnipotent, as well as loving and protective which reassures the helpless child. Years later, the child has feelings of vulnerability and experiences a desperate longing for a powerful father. The child then finds fulfillment in the
fantasy image of God as a caring protective father, yet also experiences guilt and fears resentment. The child obediently submits to God because of his projected infantile fears and this restores the lost relationship. According to Freud, religion is a dangerous illusion, a result of wish fulfillment, rather than of, observation and reason. Freud claimed that religion is dominated by prohibitions of thoughts and controls impulses by repression inspired by fear. He asserted that only by abandoning religion and its teachings and relying on science and reason can individuals and societies grow beyond the infantile stage of childhood (Freud, 1953, 1961; Wulff, 1996).

**Religion as an asset.** William James (1985) viewed religion as a way for humans to excel. He believed humans could attain excellence when inspiration and intellect are combined in equally large measures. He asserted that virtuous saints who achieve these levels of excellence will bring forth good qualities in others and will make the world a better place in which to live. He viewed religion as an essential part of life, one that performs a function that nothing else can fulfill (Wulff, 1996).

C. G. Jung (1968) was influenced by James and also viewed religion as an essential function of the human mind. He believed religion brought wholeness to the human psyche. Jung defined religion as holy and distinguished original religious experiences from dogma, rituals, and creeds, that recreate a limited version of the original religious experiences, while protecting the individuals from their overwhelming force. He asserted the existence of a deep, universal layer of the human psyche, called the collective unconscious. This collective unconscious is composed of archetypes, factors of the holy, that recreate experiences in the present of persons, situations, and processes of the collective past. Jung believed that the ultimate goal of humanity is self realization, which is guided by religious traditions. The
traditions are varied and represent the expression of the archetypes (holy factors) of the collective unconscious and symbols of self expression. He believed that participation in religious traditions brings about gradual realization of the self. If leads to individuation does not occur, disorders will develop, along with social and political upheaval in society (Wulff, 1996).

Object relations theorists including Paul Pruyser, Ian Suttie, Ana Maria Rizzutto, and Donald Winnicott saw religion as therapeutic relations. They viewed religion as a constructive part of therapy aimed at bettering personal relationships. Although they recognized the influence of both parents, they were more sensitive to the way that living relationships represent God than was Freud. They asserted that religion engages in reality testing and eases people away from hallucinatory omnipotence into acceptance of objective reality (Pruyser, 1983; Rizzuto, 1979; Suttie, 1952; Winnicott, 1953; Wulff, 1996).

Kohut, in his self psychology, viewed religion as transformed narcissism. He believed under the right circumstances, it promoted achievement of many goals of humanity including wisdom, creativity, and mystical self-transcendence (Randall, 1984; Wulff, 1996).

Erik Erikson (1963) believed religion was hope and wisdom. He thought that religion had its deepest roots in infancy and reflected the most fundamental needs, fears, and longings of mankind. Erikson believed that it universalizes trust, the ego quality that comes with the successful resolution of the first infantile stage of development, as well as a confirmation for hope, the essential strength that develops from this age. Religion creates a common faith in the trustworthiness of the universe and a universal mistrust with a shared concept of evil. Also, Erikson asserted that religion contributes to the attainment of wisdom, the final virtue desired in old age, in his final stage of ego development of integrity. For Erikson, rituals transform
impulsivity and excessive control. He saw religion as vital for the attainment of human maturity (Wulff, 1996).

Fallot (1998) advocated for the use of religion and spirituality in mental health services. Fallot asserted that religion reflects better self-understanding, a deep source of identity and meaning for consumers. Minimizing this aspect of a client’s life experience would neglect a key aspect of his/her self-definition. In addition, religion facilitates recovery and can serve as a resource of strength and growth. In addition, Fallot asserted that religion could enhance the cultural sensitivity of services, noting that many cultural groups place a high importance on religious experience and its place in healing and meaning making. Finally, Fallot observed that religion relates positively to psychosocial well-being, with a positive relationship in the empirical research between religion and positive mental health outcomes.

**Religion as both positive and negative.** Allport, Fromm and Maslow were humanist psychologists who, unlike Leuba, were more open to the existence of God. They embraced the cognitive side of religion as well as the role it plays in self-actualized persons. As humanist psychologists, they shared the believe that humankind is basically good and have a basic need to self-actualize. Individuals are unique and important and have a host of spiritual needs and values which are inadequately developed by conventional religious practices (Wulff, 1996).

One of the most influential humanists in the psychology of religion was Gordon Allport (1950). His scales for assessing intrinsic and extrinsic religious orientations serve as a foundations to much of empirical research. According to Allport, mature religious sentiment is well differentiated, with a complex arrangement of interests, issues, and object. It is dynamic and an autonomous force independent of childhood needs or its origins. It is also consistently directive, with a system of high ethical standards and comprehensive of the total human
experience. Allport believed religion is integral to a harmonious life and lends itself to self
discovery (Wulff, 1996).

Allport, with Ross, developed the Allport-Ross Orientation Scales to measure intrinsic
versus extrinsic religious orientation to prove that those who were genuinely religious differed
in their attitudes than those that were not. He discovered that individuals who displayed higher
extrinsic orientations were more authoritarian, dogmatic, and held more prejudice attitudes. He
found that intrinsic oriented individuals regularly attend church services, read the Bible and
devotional literature, participates in private prayer and meditation, and live out their religious
beliefs in their everyday lives (Allport, 1950; Wulff, 1996).

Erich Fromm (1950) wrote that individuals need some kind of orientation framework and
object of devotion to prevent anxiety associated with the reality of death and a sense of
homelessness. He believed that religion could provide these vital resources and foster the
development of human potential or stifle it. He advocated for a humanistic religion that fosters
the development of reason, compassion, and love and a sense of relationship (Wulff, 1996).

Abraham Maslow (1964) found that people who had attained a degree of self-
actualization had mystic or peak religious experiences, marked by feelings of integration and
wholeness, while existing in a satisfying present. Maslow believed that religious traditions
failed to promote these peak and mystic experiences. Specifically, the intrinsic core of religion
(mystical experiences and revelations) are displaced by the formulas, rituals, and organizations
that first symbolized and preserved the original insights but are then taken as objects to be
revered in themselves. Maslow, like Jung, thought that religious traditions could suppress
original experiences or become defenses against them (Wulff, 1996).
**Summary.** In some psychodynamic and behavioral school of thoughts, religion is seen as being closely related to maladaptive defensive behaviors, rigid ways of thinking, and distorted views of reality (Fallot, 1998). It may also cultivate dogmatic thinking, worry, depression, obsessive behaviors, prejudice, and physical abuse (Koenig, 2005). However, others have seen religion as an asset and acknowledge that it has the potential to bring positive attributes, achievements, growth, and self-actualization to its adherents. In addition, individuals often turn to religion to cope with life stressors and religion is often associated with greater well-being, more purpose and meaning in life, hope, optimism, and more prosocial traits (Koenig, 2005). And finally, there are those that acknowledge the potential for religion to be both a liability and an asset.

**Religion, culture, and meaning making.** Ecological counseling asserts that humans are not just a part of cultures or environments, but have a dynamic interactional relationship with their environments and derive meaning from them (Conyne & Cook, 2004). Specifically, human behavior is a function of persons interacting within their environments. Just as the natural, physical world cannot exit without the web of life and its interdependence, human life “depends on associations, agreements, and collaboration. Human life cannot exist apart from a network of mutually dependable and sustaining influences in the animate and inanimate world” (p. 6). Conyne and Cook further expound on the principle of ecological counseling by stating that:

Human beings are rooted in a physical environment and depend on others for nourishment and support. How each of us understands our place and our significance within this human web of life determines the manner in which we attempt to sustain our unique and communal lives. (p. 7)
Within this ecosystem of interdependence, there are a multitude of influences on a person’s life. These include biological makeup, interpersonal relationships, the physical environment, and the broader sociocultural context. These are identified as being proximal (close by and direct), or distal (distant and indirect). They can vary in their level of importance, but are ultimately intertwined (Conyne & Cook, 2004).

These dynamic, interdependent, interactional relationships take place in a variety of unique contexts or systems that are rooted in time and space. Based on Bronfenbrenner’s human ecology model, Conyne and Cook (2004) identify these systems as: microsystem, mesosystem, exosystem, and macrosystem. In the microsystem, individuals have face-to-face contact with the most influential people in their lives. This may include family members, peers, coworkers, classmates, etc. This system comprises the closest or proximal influences. The mesosystem includes relationships and connections between microsystems, that is, the way they interrelate. For example, the relationships between work and home. The exosystem includes larger systems that a person may not directly participate in but that do affect the person’s life. These include major social institutions such as local government and the healthcare system. These are identified as distal influences. And finally, the macrosystem is stated to be the most pervasive system containing “blueprints for defining and organizing social and institutional life in a society, including general values, political and social policy, and ideology” (p. 16).

Within these contexts, the most significant interactions are addressed by Conyne and Cook as ecological niche, life pattern, and life space. Ecological niche is described as the part of the ecosystem that has a regular influence on a person’s daily life, the closest direct influences. It is “where” a person lives. Life pattern, on the other hand, describes the “why” of a person’s life. It relates to the purpose or meaning-making process. A person’s life pattern is
made up of the important recurrent meanings expressed over time. Life space is referred as the combination of the ecological niche and the life pattern. It is both the objective and subjective parts of a person’s life. It is described as what an observer can see about a person’s life and the meanings that he/she ascribes to them.

The ecological perspective asserts that these person-environment interactions are subject to the meaning that is derived from them (Conyne & Cook, 2004). Life is about how we understand and perceive the world around us. Cook (2012) affirms through meaning making, people make sense of what occurs to them in everyday life. The meaning persons derive from their world can say a lot about them.

Cook (2012) asserts that meaning making accomplishes three vital tasks: communication, understanding, and prediction. We communicate through shared symbols a vast array of information about our shared public worlds and our own private worlds. We learn from others and understand the significance of a variety of things in our worlds because of meaning making. And lastly, meaning making allows us to have the limited ability to have some control of our lives by being able to predict what may happen. This ability allows us to make sense out of data that may otherwise seem random.

Thus, in the ecological perspective, not only is religion an important cultural fact and has a tremendous influence on clients’ worldviews (Dobbins, 2000; Pate & Bondi, 1992; Pincus, 1998; Richards & Bergin, 2000; Shafranske, 1996; Shafranske & Malony, 1996; Sue & Sue, 2003; Weaver, 1998). Additionally, religious meaning making addresses how people understand their place in the universe, and implications for daily life (Cook, 2012). Shafranske (1996) concurs and states that religion is a “web of significance” provided by culture and constructed by human community. According to Shafranske, religion “forms the creation of a
sense of a personal identity and provides a ‘sacred canopy’ under which spheres of relevancy are created that orient human values and ultimately determine behavior” (p. 2). Weaver (1998) confirms that religion and spirituality are important factors in most of Americans’ lives and can provide meaning, support, and affiliation.

Cox (1999) agrees that religion must be understood within the context of culture and is an important part of the meaning humans find in life. He states that humans live according to patterns of value and meaning without which life would not make sense. These patterns may be coherent or confused, elegant or slap-dash, rooted in ancient traditions or pasted together in ad hoc ways. People may adhere to them tightly or loosely, consciously or unconsciously, studiously or unreflectively. But the patterns exist. They are encoded in gestures, idioms, recipes, rituals, seasonal festivals and family habits, doctrines, texts, liturgies and folk wisdom. They are constantly shifting, mixing with each other, declining into empty usages, bursting into new life. But they are always there. Without them human existence would be unlivable. And they constitute what, in the most inclusive use of the term, we mean by ‘religion’, that which binds life together (p. 11).

Idler and George (2005) concur that the rituals engaged in by religious believers can be highly meaningful and provide people with a “culturally available scheme of shared meanings” (p. 58). Emmons (2005) says that “religious goals, beliefs, and practices are central to many people’s lives and are powerful influences on cognition, affect, motivation, and behavior” (p. 64).

Summary. Religion has been defined in a variety of ways by a myriad of individuals. It has been a subject that has historically been left for discussion by religious leaders and scholars.
However, recently it has gained the attention of other disciplines, including the mental health field. As such, it has been seen as an asset, a liability, or some combination of the two. Experts generally agree that religion is a powerful confluence of shared meanings, rituals, practices, and ideas that shape the worldviews of its participants. Therefore, it is an important subject in cultural diversity and practice.

**Pentecostal Worldview.**

**Brief overview.** Burgess notes that Pentecostalism is the second largest branch of Christianity in size (with only the Roman Catholic Church being larger) and states:

In 2000, 27 percent of all Christians (approximately 537 million) were part of the renewal, with classical Pentecostals numbering 66 million, charismatics 176 million, and neocharismatics 295 million. The combined movements are growing at the rate of 9 million per year, with the total at approximately 571 million in mid 2004” (2006, p. xiii). It is predicted that by 2025, Pentecostal Christians will number over 800 million worldwide (Harley, 2006).

Pentecostals are comprised of a heterogeneous group of Christians with varied backgrounds, races, ethnicities, socioeconomic status, and educational levels. This heterogeneous nature will continue to become varied due to the increasing numbers and globalization of the movement (Burgess, 2002; Satyavrata, 2006; Serrano, 2003; Warrington, 2008). Dobbins (2000) describes three distinct groups of Pentecostals: Classical Pentecostals, Charismatics, and Independent Charismatics. Burgess (2002, 2006) describes the three groups as Classical Pentecostals, Charismatics, and Neocharismatics. Classical Pentecostals are those denominational groups that were formed in the first two decades of the 20th century and mark their origins to several significant spiritual events that occurred from the 18th to early part of the
20th century (Burgess, 2002, 2006; Dobbins, 2000). Charismatics are comprised of Protestant denominations and Catholics who embrace a Pentecostal experience but choose to remain in their traditional churches. They were a part of the Charismatic movement (also known as the Charismatic Renewal Movement) which is usually traced back to two occurrences in Episcopalian congregations between 1959 and 1960 (Burgess, 2002, 2006; Dobbins, 2000). The third, named Independent Charismatics by Dobbins (2000), are Pentecostals who have come from the first two groups and are affiliated with independent churches outside the parent organizations. Burgess (2006) called this group the Neocharismatics and asserts that this is the largest group within modern Pentecostalism. Burgess identified this group as a catchall group that includes “independent, indigenous, nondenominational, and post denominational groups that cannot be classified as either classical Pentecostal or charismatic” (2006, p. xiii).

Oneness Pentecostals, or Apostolic Pentecostals, are usually categorized as one of three groups of Classical Pentecostals and number at least 15 to 20 million worldwide (French, 1999). French (1999) asserts that the number is closer to 20 million. The movement was birthed within twelve years of Pentecostalism, in the early 1900s, with a desire to return to Bible literalism concerning baptism and the Godhead (Beisher, 1998; French, 1999; Reed, 2002; Seagraves, 2006).

**Basic beliefs.** In spite of this heterogenous makeup, Satyavrata (2006) asserts that there is a broad agreement that the transforming experience of the Holy Spirit in a central place of importance is the “single most distinguishing feature of Pentecostalism” that “shapes their worldview definitively” (p. 219). Dobbins (2000) states that this belief that Jesus baptizes believers in the Holy Spirit today, and that they will have the “same kind of experience common to believers in the First Century Church on the Day of Pentecost”
makes Pentecostals unique among Evangelical Christians (p. 157). Pentecostals believe that the conversion experience of the disciples, the baptism in the Spirit that occurred in the upper room on the day of Pentecost, the healing and miraculous acts of the disciples, and their missionary zeal that followed are to be experienced by Christians today (Dayton, 1987 as cited in Serrano, 2003).

Serrano (2003) confirms that Pentecostalism presents a “worldview unto itself, not simply a doctrinal nuance or addition to present systems of Christian thought. The starting point for the Pentecostal worldview is decidely pneumatological, dealing with the Holy Spirit” (p. 220). Dobbins (2000) and Warrington (2008) confirm that a personal, experiential encounter with the spirit of God, that is, the Holy Spirit, is fundamental to Pentecostals. In addition to the belief in the baptism of the Holy Spirit, Pentecostals embrace a multi-dimensional nature to the universe. Whereas other Christian theologies may believe in the miracles and signs performed by Jesus and His disciples, Pentecostals believe that the miraculous, the angelic, and the demonic are all phenomena that occur within the present time. Pentecostals believe in the spiritual dimension of the world (Serrano, 2003) and embrace “a union with God’s Spirit which is real and present” (Serrano, 2003, p. 222). In addition to the work of God’s Spirit, Pentecostals believe in the work of evil, “personified in the person of Satan and his angelic followers” (p. 222). Pentecostals believe in “a universe with depth, so that the material realm reflects activity in the immaterial realm and vise versa” (Serrano, 2003, p. 222).

The belief in the Holy Spirit as an integral part of their worldview is reflected by both The United Pentecostal Church International (UPCI), and The Assemblies of the Lord Jesus Christ (ALJC), two Apostolic Pentecostal organizations, in their descriptions of their basic
fundamental doctrines found on their websites. They use the same words to describe their fundamental doctrine as the:

- Bible standard of full salvation, which is repentance, baptism in water by immersion in the name of the Lord Jesus Christ for the remission of sins, and the baptism of the Holy Ghost with the initial sign of speaking with other tongues as the Spirit gives the utterance (Assemblies of the Lord Jesus Christ, Doctrine Statement, nd; United Pentecostal Church International, What We Believe, Fundamental Doctrine, 2011).

**Divine Healing.** An important distinctive belief in the Pentecostal movement is the belief in Divine healing (Alexander, 2006; Gunther Brown, 2011; Padilla, 2006, Warrington, 2006; Warrington, 2008). Healing has always been a central expression of ministry in the Pentecostal church (Warrington, 2006) and Pentecostals believe that healing should be as prominent in the church today as it was in the first century (Dobbins, 2000; Kay, 2004; Warrington, 2008). Dayton (1996) said that divine healing was important to the development of Pentecostalism because it was evidence of supernatural gifts of the Spirit. Jesus is seen as the paradigm for healing and his healing authority has been delegated to believers today (Warrington, 2006, 2008). Although all groups in the Pentecostal movement have doctrinal statements about healing, there does not exist a singular view of healing (Belcher & Hall, 2001). Thus, common themes are explored along with varying viewpoints.

Historically speaking, Pentecostals have believed that sickness is inherently evil and is a result of the sin of Adam and Eve. Pentecostals believe that sickness may be the result of divine judgment or punishment because of personal sin or could be the result of demonic influence. However, most Pentecostals reject the idea that illness is always the result of sin or demons. They acknowledge that illness can have a natural cause. Thus, Pentecostals advocate for the use
of the Spiritual gift of discernment, that is, the ability to “discern” or differentiate the causes of an illness. In this way, believers can be aware of how they should pray for the individual who has an illness (Belcher & Hall, 2001; Warrington, 2006, 2008).

Pentecostals may vary on their views regarding whether or not believers are guaranteed healing. This is often associated with the phrase “healing in the Atonement” (Warrington, 2006, 2008). In one interpretation, healing is available to all believers because of the death of Jesus and is as easily available as forgiveness of sins. Just as Jesus forgives sins, he heals diseases. On the other hand, some Pentecostals believe that because of the death of Jesus, healing is available, though it may not always be achieved in this lifetime (Warrington, 2006, 2008). Still other Pentecostals resist the linkage of healing with the death of Jesus at all, and note that healing occurred in both the Old Testament and New Testament prior to Calvary. They see healing as a result of the sovereignty of God and his plan for each individual (Warrington, 2008).

Aside from the issue of whether healing is because of the Atonement, there have been those Pentecostals that believe that it is always God’s will to heal. Thus, this can take the form of commanding and claiming healing. As previously mentioned, this can lead to guilt, despair, and confusion if healing does not occur. However, most Pentecostals believe that God prefers to heal, but doesn’t always choose to do so (Warrington, 2006, 2008).

There have been a variety of reasons given as to why healing does not occur. These reasons are similar to those given for the causes of the illnesses themselves. Some Pentecostals cite personal sin, insufficient faith, or demonic influences as reasons. Others assert that the believer who prays for the individual could be an obstacle to healing. Some Pentecostals assert that it could simply be God’s sovereign will to not heal the individual. They assert that it could
be for the betterment of the sufferer as a part of discipline or to glorify God and reflect his character. Most Pentecostals acknowledge that God is still with those he does not choose to heal and is concerned about their eternal destiny, not just their physical well-being. The official statements of Classical Pentecostal denominations offer the hope and potential of divine healing but do not guarantee it (Warrington, 2006, 2008).

In earlier times, Pentecostals were more distrustful of medical treatment and it was deemed an inappropriate form of healing. However, today Pentecostals tend to not contrast medical healing and divine healing and do not view medical treatment negatively. It is now recognized that medicine and the skills of medical professionals are ultimately part of God’s healing. God can heal with medical help, but He can also heal miraculously without any human assistance (Alexander, 2006; United Pentecostal Church International, 2011; Warrington, 2006, 2008).

Finally, the issue of faith plays an important role in healing with Pentecostals. Authors confirm that this is often a confusing issue to many because of the variety of opinions on the matter. In many Pentecostal writings, faith is a necessary component to receiving healing. Believers are admonished to come in prayer with faith, a repentant heart, and a willingness to accept God’s will when asking for healing. Thus, believers are expected to believe that the healing will occur. Without this expectation, it is unlikely to happen. Thus, if one is not healed, their faith was insufficient. Although most Pentecostals would reject this view, it can cause difficulties for those who do ascribe to this view regarding faith and healing. It can lead to feelings of guilt and discouragement, as well as feelings of inadequacy. Thus, some Pentecostals have ignored or rejected medical advice as a sign of their faith. More commonly, Pentecostals view faith in the context of their relationships with God. Having faith in God is
about trusting that His will will be accomplished and His ways are best. They are still admonished to pray for the sick, but they trust that God is in control of the outcome (Alexander, 2006; United Pentecostal Church International, 2011; Warrington, 2006, 2008).

Apostolic Pentecostals have historically embraced the belief that healing is found in the Atonement (Alexander, 2006), but agree that there is no guarantee for healing. Believers are encouraged to ask for healing with faith in the name of Jesus, with proper motives and a willingness to accept God’s will. Apostolic Pentecostals affirm that faith in Jesus is the key to receiving healing, yet healing may not occur within this lifetime. Medical treatment is accepted with the understanding that God is the ultimate healer and can choose to heal miraculously without assistance from humanity (Alexander, 2006; Assemblies of the Lord Jesus Christ, 2012; United Pentecostal Church International, 2011).

**Faith-based practices related to healing.** The United Pentecostal Church International (2011) uses the Scripture reference of James 5:14-15 to present what Apostolic Pentecostals view as God's plan for divine healing:

> “Is any sick among you? let him call for the elders of the church; and let them pray over him, anointing him with oil in the name of the Lord: and the prayer of faith shall save the sick, and the Lord shall raise him up.” Laying on of hands and anointing with oil usually accompany prayer for healing, in accordance with God's Word and to focus faith (The Provision of Healing, paragraph 3).

Parishioners are admonished to follow the Scriptural guideline for asking for healing from an illness. This is often manifest by the member going to the altar during an appropriate time and asking the elders and leaders of the church for prayer. Church leaders gather around the member and place a small amount of olive oil onto the parishioner’s forehead. The
ministers then lay their hands on the individual’s head or shoulder. An important part of the prayer is using the name of Jesus when asking for healing. Usually during this time, more than one individual will request prayer, and a line may form as they await their turn for prayer. The clergy usually ask for the rest of the parishioners to join in prayer for the member. The believers praying for the individual, as well as the one asking for prayer, will often raise their hands toward heaven, as unto God, or toward the direction of the individual as a manner of focused prayer.

Clark (2008) points out that although anointing with oil has retained its place in the context of prayer for the sick in Pentecostal practice, “it is not viewed as being essential for a healing to occur” (p. 291). Whether or not there is believed to be any special value in the presence of the oil itself depends on the particular community of believers (Doak & Griffin, 2006). Oil was historically used within the Jewish Christian culture and symbolized the presence of God’s Spirit. Clark also points out that laying on of hands “has been regarded as an act of compassion more than a formal rite, as well as a symbolic act linking power of God with the hand(s) of the one(s) doing the action” (p. 293). This is a practice that follows the example of Jesus.

*Deliverance practices.* Pentecostals believe in the existence of evil spirits and that people can be affected by them. Some distinguish between people being “oppressed” by demons and being “possessed” by demons. Oppression refers to demons outside of the individual causing affliction, whereas possession refers to the spirit occurring inside the individual. Pentecostals uniformly agree that believers cannot be possessed by demons because they are filled with God’s Spirit. They do believe that unbelievers can be possessed. They believe that believers can be influenced (oppressed) by demons.
Most Pentecostals believe that being oppressed by demons is uncommon and being possessed by demons is even rarer. In the case that evil spirits are afflicting an individual, Pentecostals believe that he or she can be delivered from the influence of evil spirits by the power of the Holy Spirit. Thus, “deliverance refers to setting individuals free from the control, bondage, or influence of evil spirits or demons” (Henderson, 2006, p.123). Henderson points out that any Spirit-filled believer is qualified to bring deliverance to someone who suffers from the influence of evil spirits. He asserts that

The primary method of deliverance is the name of Jesus, used with a sense of authority to abjure the demon to release the person. However, even this formula may not always be necessary. The Christian carries authority over the spirits by virtue of being who she or he is in Christ. Christ has given us a certain power of attorney to act on his behalf, or in his name, without necessarily quoting the name constantly (p. 125).

Thus, believers have power over evil spirits through the Holy Spirit that dwells within them.

**Christian living.** Another area that is distinctive to some Apostolic Pentecostal Christians is the adherence to “standards” of living. These are expectations related to appearance and social activities. For example, women are expected to not cut their hair or wear pants. Or, believers are not supposed to attend theaters or dances. Palmer (2006) points out that since Classical Pentecostals have their roots in the Holiness movement, they have been affected by the social norms and mores of that movement. Palmer reports that when they were established in the early 1900s, “These social norms and mores were justified on the grounds that while spiritual and moral maturity are matters of inner life, outward appearance and behavior reflect one’s spiritual condition” (p. 177).
Although the various Apostolic Pentecostal organizations trace their roots back to the same place, many Apostolic Pentecostal organizations no longer adhere to these expectations or what many have simply referred to as “standards”. However, there are still several large organizations that continue to adhere to these expectations. For example, United Pentecostal Church International, in their articles of faith, assert that

Godly living should characterize the life of every child of the Lord, and we should live according to the pattern and example given in the Word of God…We wholeheartedly disapprove of our people indulging in any activities which are not conducive to good Christianity and godly living, such as theaters, dances, mixed bathing or swimming, women cutting their hair, make-up, any apparel that immodestly exposes the body, all worldly sports and amusements, and unwholesome radio programs and music. Furthermore, because of the display of all these evils on television, we disapprove of any of our people having television sets in their homes. We admonish all of our people to refrain from any of these practices in the interest of spiritual progress and the soon coming of the Lord for His church (Bernard, 1998, p. 33-34).

Assemblies of the Lord Jesus Christ also endorses guidelines of “holiness” that are not outlined as specifically in their articles of faith as the UPCI, but they state

…godly living should characterize the life and walk of all saints…We believe we are to cleanse ourselves from all filthiness of the flesh and spirit, perfecting holiness in the fear of God to abstain from all appearance of evil and to turn away from those who have a form of godliness but deny the power thereof…(p.10).

They discuss a Scripture about the appearance of wives and adornment as well as scriptures admonishing about differences in the apparel of men and women. They assert
Modesty is not confined to dress alone but also includes conversation and manners. Holiness is not only an inward presence of God but it is also reflected in the outward life of the Christian in his conduct in this world (2012, p. 10).

As Bernard (1998) notes, many Pentecostal groups, including some Apostolic Pentecostal groups, changed on these issues in the 1940s as they started gaining broader acceptance in society. Thus, many organizations have abandoned practical holiness teachings.

An example of an Apostolic Pentecostal organization that has abandoned the traditional standards of living identified in social norms and mores from the early history of the movement is The Apostolic Christian Network. Rather than a set code of expectations, they assert that they believe

In holiness, in actions and attitudes, by separating ourselves from evil unto the Lord. We believe that those who are called by the name of Jesus Christ should depart from iniquity, understanding that salvation from the penalty of sin only begins the process of redemption. We affirm that one of the primary works of the Holy Ghost is to create in us the character of the Lord Jesus Christ (Apostolic Christian Network, n.d., paragraph 13).

Thus, they do not ascribe to a particular standard of expectations, but discuss the concept of holiness in terms of reflecting the character of Christ. It is important to be aware of these variations among Apostolic Pentecostal Christians, as well as understand how some Apostolic Pentecostals live out their faith.

_Apostolic Pentecostal clergy._ Clergy in the Apostolic Pentecostal faith tradition are highly valued and respected. They are viewed as the spiritual leaders and shepherds of the flock. They are responsible for leading the parishioners in their relationship with God. Usually within an Apostolic Pentecostal organization, there are different levels of licensure as clergy. A person
can get a local license, a general license, and finally become ordained. Although there are Bible colleges endorsed by Apostolic Pentecostal organizations, most notably those affiliated with The United Pentecostal Church International, as well as a graduate school, a degree is not required to become licensed. The Apostolic Pentecostal organizations vary in their requirements for licensure, but none require a degree in theology or a related field. Most of the organizations require experience in ministry, along with reading material, commitment of faith agreements, and endorsement from other clergy. For example, in the United Pentecostal Church International is three levels of licensure. For each licensure, there are different requirements. However, for all of the levels, they require a significant number of readings written by Apostolic Pentecostal authors. For example, the reading list for a local license includes the Bible, ministerial manuals, two specific books, and six additional books chosen from 18 listed, and any other material required from their local board. Many of these books are ones that are also used in the affiliated Bible colleges in their degree programs. Thus, ministers are not required to have a formal education, but commonly must demonstrate knowledge acquired through independent study.

The Apostolic Pentecostals emphasize the importance of being called into ministry. In one of the required readings for a UPCI general license, Becton (1991) asserts

The preacher’s supreme task upon earth is ministering to the needs of the world and presenting the gospel to the lost and dying. Although he needs training, no one could ever learn the art of ministering simply by attending a school, class, or seminar. A person can never learn how to be a preacher. Technique can be taught; art cannot. A master chef can give an accurate recipe, but conveying the “feel” in order to make food delicious is a different matter. The preacher must have a sense of calling…Every minister should be
sure of the divine call that has brought him into the ministry of the Word. Otherwise, he may simply be choosing a career with demands that often seem unreasonable, concepts that are difficult to grasp, and realities that make “success” almost impossible to achieve. Only a divine call of God changes the demands from being unreasonable to reasonable, makes the concepts easy to grasp, and enables the minister not to be concerned about “success” anyway. A true minister does not labor for plaudits of men but for the approval of God; only eternity will reveal what he has actually accomplished (p.13-14).

Thus, although there are expectations for training and experience, the call into ministry is placed in high regard in the Apostolic Pentecostal faith tradition.

Summary. Pentecostals believe in a world composed of more than just that which can be seen with the natural physical eye, composed of a spiritual realm that is both influential and integral to their every day lives. They espouse a unique worldview distinct from other Evangelical Christians, believing the miraculous and spiritual experiences that were experienced in the first century church are available and occur today. As such, they believe that divine healing from illness is attainable if God wills it so. These beliefs in the supernatural, as well as ways they are lived out, are important to consider when discussing views regarding mental illness causes and treatments. In addition, some embrace various social norms and mores associated with the Holiness movement as exemplifying Christian living.

Beliefs Regarding Causes and Treatments of Mental Health Disorders

American public beliefs. Beginning in the 1950’s, social scientists began to study the beliefs and attitudes of the American public regarding mental illness (Phelan, Link, Stueve & Pescosolido, 2000; Starr, 1955). Starr (1955) conducted the first national survey regarding the public’s attitudes toward mental illness, using brief vignettes depicting the various mental
disorders of paranoid schizophrenia, simple schizophrenia, alcoholism, anxiety neurosis, juvenile character disorder, and compulsive phobia. Starr found that very few Americans identified the described conditions as mental illness and most often associated mental illness with psychosis (Link, 1999; Phelan et al., 2000). Starr (1955) asserted that these narrow definitions of mental illness led Americans to hold negative stereotypes of those with mental illness including unpredictability and dangerousness (Phelan et al., 2000). This study was followed by two additional national surveys both entitled Americans View Their Mental Health (Gurin, Veroof, & Feld, 1960; Kulka, Veroff, & Douvan, 1979; Veroff et al., 1976). Results from these two studies indicated that, in general, Americans in 1976 were more likely to define personal problems in mental health terms than in the 1950s, more likely to seek professional help for their problems, and less likely to adopt a self help position. Americans also displayed an overall increase in seeking mental health sources of help for their problems in 1976 than in previous years (Veroff et al., 1979). Researchers hoped these studies would bring awareness to the problem of stigma associated with mental health disorders and be an impetus to social change (Harley, 2006). Aside from these large studies, Pescosolido, Martin, Link, Kikuzawa, Burgos, Swindle, Phelan (2001) asserted that despite the changes in our understanding of mental illness in the past fifty years, there had been relatively little scientific research focused on assessing the current American public’s attitudes, beliefs, and behavior toward mental health.

In response to this lack of research, Pescosolido et al. (2001) created a module entitled the MacArthur Mental Health Module (MMHM) which was included as part of the 1996 General Social Survey (GSS). The General Social Survey is part of an ongoing project conducted by The National Opinion Research Center that has investigated the American
public’s attitudes on a variety of topics since 1972 (General Social Survey, n.d.). Pescosolido et al. (2001) utilized the data from the MMHM, along with the aforementioned studies (Gurin, Veroff, & Feld, 1957; Starr, 1955; Veroff, Douvan & Kulka, 1976) to investigate the American public’s views on mental health. They examined the public’s ability to recognize mental illness and substance abuse, their beliefs about the causes of mental health problems, opinions on the best treatments for mental health issues, comfort level with people who are mentally ill, their attitudes on legal issues surrounding involuntary treatment, and who should be responsible for the cost of mental health care.

The MMHM, developed by the team of researchers, consisted of five vignettes depicting Major Depression, Alcohol Dependence, Cocaine Dependence, Schizophrenia, and Troubled Person. These were chosen based on their prevalence, severity, and potential consequences of misidentification. Participants were told one of the five vignettes and were asked to respond to a series of questions to assess whether or not the person described had a mental illness, how serious the problems was, and the cause of the problem.

Pescosolido et al. (2001) found that the majority of participants were able to correctly identify the specific disorder described in the vignette and most agreed that the four problems that described a mental health disorder were “very serious.” In regard to causes, there was not a uniform response attributing the cause of mental health disorders to genetic/medical, social structural, or individual level causes. Researchers found that drug dependence was the only disorder for which the respondents attributed an individual-level cause (bad character reported by 31.5%). For schizophrenia, on the other hand, chemical/biological attributions were prominent, with nearly half of all respondents (46.9%) very likely to attribute the cause to a chemical imbalance. For depression and alcohol dependence, respondents were more likely to
endorse social structural attributions (i.e., stress) as causes. A majority (54.5%) of respondents attributed depression to problems related to dealing with daily stressors and 36% attributed alcohol dependency to these stressors as well. More than half (54.5%) believed depression was caused by stressful circumstances. Only a very small number of participants attributed “God’s will” to the cause of any of the four mental health problems (Pescosolido et al., 2001). When asked about the treatment for the mental health disorders presented, the majority of Americans interviewed concluded that it was unlikely that the problem would improve on its own but was likely it would improve with treatment. Participants endorsed a wide array of possible sources of treatment for the mental health disorders depicted in the vignettes. Seeking help from family and friends was the most frequently endorsed source of help (95.3%), followed by self-help groups, clergy, mental health therapists/counselors, physicians, psychiatrists, and prescription medication. About 30 percent said the person should check into a mental hospital; 20.8% suggested seeing a spiritual or natural healer; and only 7.8% recommended non-prescription medication. It was noted that when the vignette depicted a person with schizophrenia, 91.6% recommended seeing a psychiatrist and 61.6% endorsed checking into a mental hospital as well. Also, respondents endorsed prescription medication for persons suffering from both schizophrenia (83.4%) and depression (74.7%) (Pescosolido et al., 2001). When asked to rank order these sources of help for the four mental health problems, a clearer picture developed. Seeking help from family and friends was the preferred first choice for 50.9% of the participants. Only two other sources were chosen by more than ten percent: seeing a medical doctor (16.9%) and seeing a therapist/counselor (10.4%). Although seeking the help of clergy was highly endorsed, it was the first choice for only 9% of the people.
Pescosolidio et al. (2001) found that compared to those in 1957 and 1976, Americans were more likely to endorse prescription medication and mental health professionals when faced with a mental health disorder. In addition, they were much less likely to seek a physician for help. The 1996 survey indicated that Americans were more willing to endorse prescription medication for the treatment of depression and schizophrenia.

In addition, Olafsdottir and Pescosolido (2009) found a relationship between Americans’ causal attributions and treatment endorsements using data from the 1996 Mental Health Module of the General Social Survey. Olafsdottir and Pescosolido found that individuals discriminated between treatment providers based on their evaluation of the problem, underlying causes, and possible consequences. When participants perceived a severe problem, they endorsed all forms of professional care. However, when problems were attributed to biological causes, researchers found that the Americans interviewed endorsed general or specialty medical providers (i.e., doctors, psychiatrists, and hospitals) as treatment; disorders matching symptoms for schizophrenia or believed to produce possible violence were recommended to the specialty mental health sector (i.e., psychiatry, mental hospital); and those problems viewed as being caused by stress were sent to nonmedical mental health providers (e.g., counselors).

When the General Social Survey was replicated in 2006, Pescosolido, Long, Medina, Phelan, and Link (2010) compared the data from the 1996 and 2006 mental health modules to determine if beliefs and attitudes of the American public had changed in regard to Schizophrenia, Major Depression, and Alcohol Dependence. Specifically, they examined whether the American public had embraced neurobiological explanations for mental illness, whether they endorsed professional treatment options, especially psychiatrists, and if the stigma associated with persons with mental disorders had decreased. They found significant changes in
Americans’ views on causes and treatments of mental illness. However, stigmatization of those with mental health disorders did not decrease (Pescosolido et al., 2010).

They found that more of the public endorsed neurobiological attributions to mental illness, with a significant increase (6 to 13%) across all vignettes and nearly all indicators. Specifically, an increase of 10 percentage points for schizophrenia (from 76% to 86%) was reported, 13 points for depression (from 54% to 67%) and nine points for alcohol dependence (from 38% to 47%). In conjunction, social or moral conceptions of mental illness decreased across most indicators, and there was a significant decrease in Americans Viewing “ups and downs” as a cause for alcohol dependence.

As far as treatment, Pescosolido et al. (2010) found an increase in the American public’s endorsement of medical treatment. They found that the large majority supported both general and specialty care for individuals with mental illness. They also reported that over 85% of the American’s interviewed endorsed seeing a psychiatrist for major depression (compared to 75% in 1996), and 79% recommended psychiatric treatment for alcohol dependence (from 61% in 1996). A significant increase in endorsement of prescription medicine was also found across all vignette conditions. Treatment at a mental hospital was the only medical treatment that remained unsupported by a majority of respondents for depression or alcohol dependence. However, just as in 1996, Americans supported hospitalization for individuals with schizophrenia, with a significant increase (from 53% to 66%) reported (Pescosolido et al., 2010).

Summary. Thus, according to these studies, the American public’s views on the causes and treatments of mental health disorders has included a variety of opinions, with some change reported over the years. Americans have become better at identifying personal problems in
psychological terms and have embraced a variety of causal attributions, as well as treatment options for mental illnesses. Research indicates that Americans believe that mental health disorders can be caused by genetic/biological factors, social/structural factors, and individual factors. Yet, Americans have increased belief in the biological causes and decreased beliefs in individual/moral causes of mental health disorders. In similar fashion, Americans have supported a variety of treatment options for mental illness including family and friends, physicians, mental health professionals, clergy, and prescription medication, while increasing their willingness to seek professional medical treatment.

**Christian beliefs.** The aforementioned studies (Olafsdottir & Pescosolido, 2009; Pescosolido, 2001; Pescosolido et al., 2010) on the mental health beliefs of Americans, along with those generated by these data sets (e.g., Schnitker et al., 2000) and others included the cultural considerations of ethnicity, gender, education, socioeconomic status, marital status, working status, and community size but failed to investigate adequately religious factors as cultural variables affecting beliefs regarding mental health.

In response to this lack of research on religious factors affects on beliefs regarding mental health, Stanfield (2002) used the data sets in the 1996 General Social Survey and 1998 General Social Survey to investigate “Bible believers” beliefs about mental health disorders. Stanfield (2002) differentiated Bible believers as those respondents of the 1996 and 1998 GSSs who believed that “the Bible is the actual word of God, and is to be taken literally, word for word” (p. 61) with those who did not endorse a literal word for word understanding of the Bible. Stanfield reported that this was used as a descriptor to attempt to study Christians more likely to be identified as “fundamentalist” Christians, although he acknowledged that only 58% of those he categorized as Bible believers identified themselves as both Christians and fundamentalists.
Stanfield compared the Bible believers’ responses regarding mental health in the 1996 MMHM to the rest of the population of participants, as well as their beliefs regarding prescription medication as outlined in the Pressing Issues in Health and Medical Care Module in the 1998 survey.

Stanfield (2002) found that the Bible believers were more likely than the other GSS respondents to endorse “bad character” as the cause of the person’s problem depicted in the MMHM modules (56% compared to 41%). However, contrary to his prediction, they were just as likely as the other respondents to attribute the problems to a “chemical imbalance.” Bible believers were more likely than the other respondents to endorse talking to a minister or other religious leader (90.2% compared to 78.5%). However, also contrary to Stanfield’s hypotheses, the Bible believers were just as likely as the other GSS respondents to say that the persons depicted in the vignettes should see a psychiatrist, take prescription medication, and see a mental health professional. Yet, when comparing the results of the 1998 Pressing Issues in Health and Medical Care Module regarding prescription medication, the Bible believers were more likely than the other respondents to say that individuals should stop taking psychiatric medications when symptoms subside (Stanfield, 2002).

Belairie and Young (2002) surveyed 100 church members to investigate possible interactions between religious commitment, denomination, and attitudes toward counseling. They found that highly conservative Christians expected more religious behavior from secular counselors during sessions. These therapy practices included reading of Scriptures, prayer, and using religious language. Both moderately and highly conservative Christians expected secular counselors to “respect their religious autonomy, to be accepting of religious beliefs and practices, and to have an open attitude toward religion” (pp. 183-184). Pentecostal Christians in
the sample \( n = 5 \) displayed a significant difference on ten subscales related to counseling expectations. In a similar study, the same authors (Belaire, Young, & Elder, 2005) found that conservative Christians expected both a Christian counselor and a counselor whose religious beliefs were unknown to use religious behavior (e.g., reading Scripture, praying, using religious language) in counseling sessions.


Thompson investigated whether Protestant Christian beliefs regarding mental illness and help seeking behaviors would be affected by intrinsic versus extrinsic religiosity. Thompson found that those with extrinsic religious orientations held different beliefs regarding mental illness than those with intrinsic religious orientations. There were no differences in regard to help seeking behaviors. Also, Thompson found a positive correlation with extrinsic religious orientations and negative stereotypical beliefs of mental illness.

**Summary.** These studies indicate that Christians can hold both similar and different beliefs from the general public regarding the causes and treatment of mental health disorders. On the one hand, conservative Christians did attribute more individual causes, specifically bad character, to mental illness (Stanfield, 2002); endorsed clergy as a treatment option more often (Stanfield, 2002); expected treatment to include religious practices (Belaire & Young, 2002;
Belaire et al., 2005); and were less likely to seek treatment for mental illness (Thompson, 2010). These findings support earlier studies that found religious conservative individuals linking mental health disorders to sinful behavior, ignoring God’s direction, doing something against God’s will, moral weakness, and the influencing by the demonic (Fraser, 1994; Neff & Husaini, 1985). Findings were also consistent with studies that found that people are likely to turn to clergy for help (Blank et al., 2002; Burgess, 1998; Chalfant et al., 1990; Franklin & Fong, 2011; Koenig, 2005; Larson, et. al., 2000; Pickard & Guo, 2008; Wanget al., 2003). On the other hand, Christians simultaneously endorsed biological causes in addition to the individual causes and supported seeking help from mental health professionals, psychiatrists, and prescription medication (Stanfield, 2002).

**Pentecostal Christian beliefs.** There are three key studies (Harley, 2006; Koller, 1994; Trice, 2003) with Pentecostal Christians on their beliefs regarding causes and treatments of mental health disorders. In an exploratory study, Koller (1994) studied Charismatic Christians’ beliefs regarding mental illness. Fifty-four adults who attended one of five Charismatic churches in the Tulsa, Oklahoma area completed a 50 item questionnaire regarding beliefs related to seven areas of mental illness: depression, anxiety, multiple personality disorder, addiction, dementia, homosexuality, and suicide. She identified the possible causes of mental illness as physical, spiritual, emotional, or a combination of causes. Five broad areas for treatment of mental illness were specified: general issues, medication, hypnotherapy, treatment in a Christian environment, treatment in a secular environment, and combination of therapies. The final area of measurement was associated beliefs surrounding mental illness. According to Koller (1994), this area included items that did not directly fall into any of the previous three categories. Each of the 50 items was presented as a statement, with participants being given a
choice of answers on a 6 point Likert scale. The possible answers ranged from 1 “Strongly Agree” to 6 “Strongly Disagree.”

Koller found the following ten beliefs held by charismatic Christians regarding mental illness:

(1) there is a physical dimension to mental illness; (2) there is a spiritual dimension to mental illness; (3) treatment should include both physical and spiritual methodologies; (4) the mind, the soul, and the spirit are integrated within a person; (5) treatment can be harmful if it does not consider the spiritual realm of a person; (6) there may be some differences between mental illness caused by a physical disease and mental illness caused by demons; (7) mental illness can be influenced by issues commonly dealt with in a spiritual context such as forgiveness, renewal of the mind through the Word of God, demons, or other wicked spiritual forces; (8) sometimes people can distort scripture through the eyes of a mental illness; (9) a charismatic Christian should not seek help from a non-Christian mental health professional; and (10) a Christian should never allow themselves to be hypnotized, even by a trained Christian therapist (1994, p. 73).

Thus, the charismatic Christians in this study believed in a combination of physical and spiritual causes and treatments for mental health disorders, as well as a belief in not seeking help from a non-Christian mental health professional.

In another study with 230 Pentecostal Bible college students, ages 18-27, Trice (2003) examined their beliefs of the causes and treatments for major depressive disorder. Participants completed a 32 item survey to assess their beliefs concerning the causes of depression, and a 25 item survey to assess their beliefs of effective treatments for depression.
From the 32 possible causes of depression, Trice’s analysis yielded seven factors or scales. These were labeled *Social Relational, Lack of Faith, Finances, Loss of Control, Death Issues, Victimization, and Biology*. The *Social Relational* scale included items of “marital trouble, having poor relationships with one’s children, racism, having a drug problem, being homeless or imprisoned, and being lonely” (p. 16, 17). The *Lack of Faith* scale included “a lack of faith, disobedience to God, punishment from God, and negative thinking” as possible causes (p. 17). “Financial difficulties, being laid off, and unemployment” were included in the *Finances* scale. The *Loss of Control* scale referred to the items of “having a terminal illness, old age, and discovering one was adopted.” The *Death issues* scale involved items relating to the death of various loved ones. The *Victimization* scale “included items concerned with being an abuse victim, demon oppression/possession, and being raped” (p. 17). The final scale, *Biology*, “included genetics, chemical imbalance, and brain abnormality as causes of depression” (p. 17).

Trice found that *Victimization* and *Death Issues* were believed to be more likely to cause depression than all the other factors. Thus, the Pentecostal students were more likely to attribute causes of depression to forces outside of the individual’s control. The Pentecostal students did not cite spiritual determinants as causes of depression as Trice had hypothesized (2003). However, Trice noted that even though the *Lack of Faith* factor received the lowest mean rating of all the scales, the faith related item of “demon possession” which factored on the *Victimization* scale received the fourth highest mean rating out of all 32 items. This led Trice (2003) to assert that the Pentecostal Bible college students may have believed in some causal link of lack of faith as a cause of depression. Trice acknowledged that these findings support other research which indicates that individuals often hold several, and sometimes contradictory, theories regarding the causes of mental health disorders.
Trice (2003) asserted that the endorsement of the more biological causes of depression by this population was surprising, in that it contradicted previous Pentecostal literature’s emphasis on spiritual etiology for mental distress which indicated that mental health disorders were the result of disobedience to God’s commands, a work of the devil, etc. Trice acknowledged that this study suggested that the Pentecostal students were more aware of the complexity of mental health issues than had previously been thought of those in the Pentecostal faith tradition.

In regard to the treatment of depression, Trice (2003) reported seven factors from the possible 25 treatment options. These factors included Faith, Psychology, Social Support, Rest, Neuropsychology, Health, and Discipline. Faith included “memorizing Scripture, confessing sin, fasting, praying with ‘laying on of hands’, deliverance/exorcism, individual prayer, and avoiding yoga” (p. 17). Psychology included “therapy with a psychologist, taking antidepressants, hospitalization, and talking with a physician” (p. 17). Social Support involved “making new friends, family time, pastoral counseling, and joining a support group” (p. 18). Rest included “both sleep and relaxation/vacation time” (p. 17). Neuropsychology referred to “brain surgery and electroconvulsive therapy” (p. 18). Health included “positive thinking, herbal medicine, and changing one’s diet” (p. 18). The final factor, Discipline, included “reading the Bible and exercise” (p. 18).

In contrast to the multiple causal attributions endorsed by the participants, Trice (2003) found that the Pentecostal students endorsed the expected faith practices as the most effective treatments. Discipline was ranked as the most effective treatment for depression, followed by Faith, Rest, Social Support, Health, Psychology, and lastly Neuropsychology. The Discipline item reading the Bible was the most highly endorsed item on the treatment scale. The Discipline scale coupled with the Faith scale was endorsed over all the other treatment scales.
In addition, the participants reported that they were unsure if *Psychology* (included taking medication and therapy) was an effective treatment. Trice reported that these beliefs regarding effective treatments confirmed previous studies that confirmed Pentecostals’ belief in healing, as well as their suspicions of secular psychology.

Trice also found that the participants’ experience with depression may have affected their beliefs regarding the causes and treatment of depression. The more experience the participants had with depression, the more likely they were to endorse *Biology* and *Finances* as causes. And the more depressive symptoms reported, the less likely they were to endorse *Discipline* and *Lack of Faith* as effective treatments.

Thus, Trice’s (2003) study shared some results congruent with Koller’s (1994) study. The Pentecostal students attributed mental illness to multiple causes. And even though they did not indicate spiritual determinants as causes for mental illness in general, they supported the idea that demon possession could cause mental illness, indicating some support for the causal link between lack of faith and mental illness. Also, they endorsed practices that embrace faith and the spiritual as treatments for mental illness, while not supporting treatment by secular mental health professionals.

In a final key study with Pentecostals, Harley (2006) used the results of the General Social Survey of 1996 and selected questions from the MacArthur Mental Health Module (MMHM) to compare the beliefs of Pentecostal Christians with the general population. Harley investigated the beliefs of Pentecostals with varied backgrounds from three different churches concerning the causes and treatments of major depressive disorder and schizophrenia. As noted previously, the MMHM was developed by a team of mental health experts and used vignettes to
study the attitudes toward mental health disorders and mental health services (Pescosolido et al., 2001). Harley added to the original MMHM by adding items associated with Pentecostals.

Harley (2006) used only the causal and treatment components of the MMHM and used two of the five vignettes presented in the MMHM: one vignette depicting a character with symptoms of major depressive disorder, the other depicting a character displaying symptoms of schizophrenia. After each vignette, participants were given a series of questions regarding the causes and treatments of the problems presented. Harley (2006) added “demonic forces,” “sin,” and “lack of faith” to the choice of causes of “bad character,” “a chemical balance in the brain,” “the way he/she was raised,” “stressful circumstances in his/her life, “a genetic or inherited problem, and “God’s will” originally presented in the MMHM. These additional items were added based on literature regarding Pentecostals. Harley reported that “demonic forces” has appeared in several studies with samples of Christians (Cinnirella & Loewenthal, 1999; Koller, 1994; Trice, 2003), has traditionally been embraced by a high percentage of Christians, and as mentioned previously, was ranked 4th out of 32 causes for major depression disorder in Trice’s study. The item “sin” was added because of its high endorsement in Trice’s study (8th out of 32). “Lack of Faith” was added because of its positive endorsement and its implications in seeking treatment. With the treatment options, Harley (2006) added six items: “read Scripture,” “praying with laying on of hands,” “confession of sins/repentance,” “seek deliverance,” “hypnosis,” and “seek a Christian counselor.” These were added to the original MMHM treatment options. The first four were added based on their high endorsement in Trice’s (2003) study. “Hypnosis” was added based on Koller’s (1994) study, which found that Pentecostals were against hypnosis. The final “seek a Christian counselor” was added as an exploratory item.
Harley found that 68.2% of the Pentecostals endorsed “stressful circumstances” as the most likely cause of major depressive disorder. This was followed by “demonic forces” (27.4%) and “chemical imbalances in the brain” (20.8%). “Lack of faith” was endorsed by 19% of the participants and 18.9% believed that “unforgiven sins” very likely causes major depressive disorder. In comparison, Harley found that 54.1% of the participants believed “demonic forces” caused schizophrenia and 46.7% endorsed “chemical imbalances in the brain” as the cause. “Stress” was the cause endorsed third by 39.6% of the participants. “Lack of faith” and “unforgiven sins” were moderately endorsed with 22.7% and 20.9% of participants, who believed these spiritual factors cause schizophrenia. Only 17.4% believed that “genetics or an inherited problem” causes schizophrenia.

Thus, Pentecostals in this study embraced stressful circumstances, biological causes, and demonic forces as causes for major depressive disorder and schizophrenia. However, there were distinctions between their beliefs in these causes for these disorders. Stressful circumstances were seen as causing depression, with demonic forces and biological causes being moderately endorsed simultaneously. However, for schizophrenia, they believed it was caused more by demonic forces and biological causes. These results support the previous studies by Koller (1994) and Trice (2003) where Pentecostals embraced multiple causes for mental disorders, as well as spiritual components not endorsed by the general public. However, when compared with the general population, Pentecostals were no more likely to blame the causes of major depressive disorder and schizophrenia on personal factors (“bad character” or “the way one was raised”). This finding contradicts Stanfield’s (2002) results where conservative Christians endorsed bad character more often than the general public. This suggests that Pentecostals are more likely to endorse factors that support their spiritual belief in
outside influences (i.e., demonic forces) rather than individual personal factors. Pentecostals were just as likely as the general public to endorse a chemical imbalance as a cause. Pentecostals were found to be less likely to assert that either was caused by “genetics” (Harley, 2006). Thus, Pentecostals acknowledged the physical nature of mental illness and stressful circumstances as the general public, yet they also embraced a spiritual component to causes of mental illness, specifically schizophrenia.

As far as beliefs regarding treatments, Harley (2006) asked participants to select “yes” or “no” to each treatment option, as well as rank order their preferred treatment options. The most frequently endorsed treatment option for major depressive disorder was “reading Scripture” with 99.2% of participants marking it as a treatment option. “Talking to pastor/minister” and “seeing a Christian counselor” were also highly approved with 98.8% endorsement. “Laying on of hands” came in a close fourth with 98% of the participants acknowledging this as a treatment option for major depressive disorder. “Talk to family or friends,” “repent or confess sins,” and “seek deliverance” were also positively endorsed.

Treatment preferences of the Pentecostal participants for major depressive disorder were clearer when Harley asked them to rank order them. “Talk to family and friends” was the first treatment choice for 25.7% of the participants. “Talk to pastor/minister” was the first choice for 18.5% and “read Scripture” was the first choice for 16.7% of the participants. “Repent or confess sins” was endorsed by 14.5% as the first treatment choice, and “seek a Christian counselor” was endorsed by 11.5% as the first treatment choice. The following treatment options each received less than ten percent endorsement as their first choice: “go to a general medical doctor for help,” “laying on of hands,” “go to a psychiatrist,” “go to a mental health professional,” and “take prescription medication.” None of the participants chose “take
nonprescription drugs,” “check into a mental hospital,” “join self help group,” or “hypnosis” as their first treatment choice for major depressive disorder (Harley, 2006).

In regard to schizophrenia, “laying on of hands,” “read Scripture,” “seek a Christian counselor,” “talk to pastor/minister,” “seek deliverance,” “repent/confess sins,” and “talk to family and friends” were all highly positively endorsed as treatment options. However, in contrast to major depressive disorder, the Pentecostal participants also positively endorsed the secular treatment options for schizophrenia. “Go to a mental health professional” was approved as a treatment option by 80.7% of the participants. Also positively endorsed were “go to a general medical doctor” (75.9%), “go to a psychiatrist” (73.6%), and “take prescription medication” (71.7%) (Harley, 2006).

Although the Pentecostals positively endorsed secular treatments as options for schizophrenia, when they were asked to rank order their treatment preferences, the highest percentage (23.4%) chose “talk to family and friends” as their first treatment choice. These were followed by the spiritual treatments of “talk to pastor/minister” (16.2%), “repent/confess sins” (11%), “seek a Christian counselor” (10.9%), and “read Scripture” (10.6%). Over nine percent did choose “go to a psychiatrist” as their first choice, and over seven percent chose “go to a general medical doctor for help” as their first treatment choice. The treatment options receiving fewer endorsements as first choice included “laying on of hands,” “check into mental hospital,” “seek a mental health professional,” “take prescription medication” and “join self help group.” No one chose “nonprescription medication” or “hypnosis” as their first treatment choices for schizophrenia (Harley, 2006). The Pentecostals were less likely than the general population to endorse prescription medication as a treatment option for schizophrenia or major depressive disorder.
Thus, Harley’s study found that for major depressive disorder and schizophrenia, Pentecostals chose family and friends as their first preferred treatment choice. This was congruent with the original 1996 study (Pescosolido, 2000) where the American public chose family and friends as their first choice across all five mental health disorders presented. However, this study was also congruent with Koller’s (1994) and Trice’s (2003) studies that found Pentecostals also highly endorsed faith based treatments. The Pentecostals in this study endorsed talking with clergy members as their second choice for treatment. They also embraced reading Scriptures, repenting of sins, and seeking help from a Christian counselor over secular mental health treatments for major depressive disorder and schizophrenia. Even though they acknowledged secular treatments for schizophrenia, they still preferred the faith based treatments as a first step. This supports the idea that Pentecostals believe that mental health disorders should be treated with faith-based activities by clergy and/or a Christian mental health professional before secular treatments by non-Christian mental health professionals.

Summary. As noted above, these three studies (Koller, 1994; Trice, 2003; Harley, 2006) led to significant findings regarding the Pentecostal Christians’ beliefs regarding the causes and treatments of mental health disorders. All three found that Pentecostal Christians endorsed a variety of causes, often contradictory to one another, of mental health disorders, including circumstantial, biological and spiritual. Koller (1994) confirmed that Pentecostals believe in physical and spiritual causes for a variety of mental health disorders; Trice (2003) found stressful circumstances outside of one’s control, as well as demon possession were endorsed as the most likely to cause major depressive disorder. Additionally, Harley (2006) found that stressful circumstances, demonic forces, and biological factors were believed to be the top leading causes for major depressive disorder, and demonic forces, chemical imbalances in the
brain, and stressful circumstances were believed to most likely cause schizophrenia. And although Pentecostal Christians acknowledged a variety of causes for mental health disorders, they preferred faith based treatments over secular mental health treatments, wanted to first seek help from family and friends, and were often resistant to medication. And, finally, Harley and Trice both found that Pentecostals preferred seeking help from their clergy before seeking help from a mental health professional.

_Clergy beliefs._ As the aforementioned studies with Pentecostal Christians have shown, other studies (Blank, et. al., 2002; Burgess, 1998; Chalfant, et. al., 1990; Franklin & Fong, 2011; Koenig, 2005; Larson, et. al., 2000; Pickard & Guo, 2008; Wang, et. al., 2003) confirm that those with mental illnesses and social problems are more likely to turn to their clergy for help than to mental health professionals. Burgess (1998) notes that although the primary concern for the local pastor is to be the spiritual leader, he/she may be asked to perform a variety of tasks associated with his/her role. In addition to being a preacher, an educator, an administrator, a care-giver, and even in small churches, a secretary, a pastor is also “a counselor, a healer of the hurts of the living” (p. 2). Lafuze, Perkins, and Avirappattu (2002) acknowledge that churches are important community resources offering support to persons in need. Clergy are often readily available in times of crisis and are highly trusted by their members. Thus, examining clergy beliefs regarding causes and treatments of mental health disorders would contribute to understanding the way Pentecostals view mental health disorders.

Researchers have found that clergy endorse a variety of causes for mental health disorders (Azlin, 1993; Gaston, 2000; Lafuze, et. al., 2002). Lafuzeet al. (2002) surveyed 1,031 United Methodist pastors in Indiana and Virginia about the causes of mental disorders, perceptions of people with mental disorders, and views of medications and other treatments.
They found that the pastors had “mainstream, up-to-date views about the causes of mental disorders” (p. 1176). Three biological causes of mental disorders (chemical imbalance, excessive use of drugs or alcohol, and inherited genes) were perceived as more important than the three psychosocial causes of inconsistent parenting, social pressure, and spiritual poverty. They reported that the six biopsychosocial variables were seen as very important or somewhat important causes of mental disorders by more than half of the participants (54 to 94%). All of the remaining causes, which included luck or fate and explicit religious interpretations, were viewed as not important in causing mental disorders by 60 to 83% (Lafuze et al., 2002). Also, in this sample, the majority agreed that mental illness is not caused by individual causes.

Regarding treatment, they found that most of the pastors endorsed prescription medication and were neutral about or disagreed with statements that prayer and counseling were more important than medication in treating mental disorders. The researchers believed that there could be successful collaboration between clergy and mental health professionals based on their biopsychosocial understanding of the causes of mental health disorders, as well as, their endorsement of prescription medication.

Thus, in this sample, clergy saw biological causes as more important than the psychosocial causes, and likewise endorsed biological treatments including prescription medication. These findings are in contrast to the studies on conservative Christians. This may reflect the fact that Methodists tend to be less conservative than other Protestant Christians. Azlin (1993) interviewed 54 fundamentalist pastors about attitudes toward mental health professionals and services, beliefs about causes of mental health disorders, their perceived competency to treat mental health disorders, and how the attitudes expressed related to referral practices. The questionnaire used consisted of four parts. The first part included three scales:
Attitudes Toward Mental Health Scale, Causes of Mental Illness Scale, and Perceived Competency Scale. The second part consisted of five hypothetical case histories where the pastors were asked questions about diagnosis, their role in the treatment of the individual, any referrals made, and morality of the problem. The third part was comprised of a 15 item Inventory of Religious Belief used to assess orthodox fundamentalist Christian beliefs. The final part included demographic questions.

Azlin found a significant negative correlation between the pastors’ perceptions of their own competency to treat mental health disturbances and their attitudes toward mental health professionals, in that the pastors in the sample tended to agree that mental health professionals were competent and positive toward their patients. They disagreed with the statement that “emotionally disturbed parishioners should not be a clergy’s responsibility, and should therefore be referred” (p. 15). They also disagreed with the statement that the work of mental health professionals conflict with the work of the clergy.

With regard to the beliefs of the causes of mental illness, Azlin found no relationship between the pastors’ beliefs regarding causes of mental illness and either their attitudes toward mental health professionals or their perceived competency to treat mental health disorders. They endorsed causes of excessive drug use, demonic influence, and stress. The possible fourteen causes offered were those used in the 1960s (Larson, 1965) and may not offer the best representation of possible causes.

Azlin (1993) also found a negative correlation between the number of pastors’ training hours in counseling and their perceived competency to treat mental health disorders. Pastors believed they were competent to treat individuals with emotional disturbances and were comfortable in doing so. However, the more training a pastor had obtained, the less their self-
perceived competency. Azlin suggested that when pastors become more aware of the complexity of the human psyche, they feel less competent to treat emotional disturbances. She also found a positive correlation between the number of people the pastors saw and referrals made to mental health professionals.

Gaston (2000) conducted a needs assessment of clergy in order to understand specific needs, skills, and resources needed as they minister to people that have mental illness. Baptist, Catholic, Lutheran, Mennonite, Nazarene, Presbyterian, Methodist, Church of Christ, Evangelical, Friends, Eastern Orthodox, Nondenominational, and Jewish ministers were included in the sample. The needs assessment was a 60 item inventory consisting of needs assessment items, role theory items, a scaled measure of theological status and social involvement perspectives, and demographic data.

Gaston’s needs assessment items consisted of three sections: ways to minister to people with mental illness and the perceived helpfulness of each way, possible helpful resources and skills, and training and education related to mental disorders that would be helpful. The role theory items asked the clergy about their roles in helping people with mental illness and the strengths and challenges they encountered while dealing with mental illness. The scale of theological status and social involvement measured status as theologically conservative versus theologically liberal, as well as involvement as socially conservative and socially liberal.

A scale assessing the clergy’s beliefs regarding causes of mental health disorders was included in their assessment.

Clergy believed genetic causes and problems in living to be the most significant causes. Gaston noted that the participants indicated that they believed that these two causes were intertwined in causing mental health disorders. Interestingly, “religious concerns” was the least
endorsed cause for mental health disorders, with 33.3% of the respondents saying that they disagreed that religious concerns caused mental illness and another 30.5% reporting that they probably disagreed. However, 64.8% either agreed or probably agreed that “spiritual conflict” caused mental illness. These results seem to indicate that although the clergy did not believe religious concerns caused mental illness, there is some belief in a spiritual component to mental illness.

When the clergy were asked to describe their roles when helping those with mental illness, the most frequent response was “to encourage the person to get help by following up with a referral to a mental health professional, an agency or hospital, or with a physician” (Gaston, 2000, p. 30). In addition, the clergy surveyed reported that they listen carefully, assess the problem, offer emotional support, provide appropriate treatment, and follow up with the church member after their referral for additional help. Gaston also found that the clergy reported making more referrals and following up on those referred. This was especially true for mental health professionals who held similar religious beliefs. The clergy in this study also reported a better understanding that mental illness is a legitimate medical concern and are better able to recognize symptoms of mental illness. The clergy felt their strengths when ministering to those with mental illness were listening, making referrals, providing compassion, providing spiritual support, being available and knowing their own limits, having experience with mental health work, and providing support during mental health treatment. When asked about the different ways they ministered to people with mental illness, they agreed that they provide initial support, offer referrals, and suggest other means for finding spiritual and emotional support within their church families.
One third of the clergy in Gaston’s study reported that their challenge while ministering to those with mental illness was assessing the need of the person needing help. They wished to stay in their areas of expertise and were unsure the best course of actions to take as well as when to refer. Clergy positively endorsed the need for all of the resources and training items listed on the study. The resources included having a list of resources, a list of services, a list of mental health centers, a list of physicians, and a list of self-help groups; the need for training included the areas of counseling family members, information regarding symptoms of mental illness, counseling those with mental illness, and building church support.

Although Koller (1994) did not specifically study Pentecostal clergy’s beliefs, she observed significant differences between some beliefs of those who identified as Charismatic ministers and those who identified as Charismatic medical personnel. In regard to causes of mental illness, 63% of the ministers tended to agree that “the reason a Christian gets mentally ill is because he has sin in his life that he has not dealt with” (p. 64); 60% of the medical personnel disagreed with this statement. Sixty-four percent of clergy “tended to agree that alcoholism is a sin, rather than a disease” (p. 65); 80% of the medical professionals disagreed. And, 25% of the ministers “were not sure but tended to agree that severe anxiety and panic are the result of not trusting in the LORD” (p. 64), but 80% of medical personnel disagreed. In regard to treatment, a high number (76%) of ministers “disagreed that charismatic Christian beliefs and traditional treatment of mental illness were compatible” (p. 65); whereas 100% of the medical personnel agreed that they were compatible. Sixty-three percent of the ministers “agreed that renewal of the mind through the Word” (p. 64) could heal mental illness and 60% of the medical personnel disagreed with this statement. Also, 76% of the ministers “agreed that charismatic Christians should not seek help from non-Christian, mental health professionals” (p. 65); 80% of the
medical personnel disagreed. And finally, the ministers were opposed to hypnotism: 63% of ministers strongly agreed that hypnotism was a dangerous method of treatment, whereas there was no such consensus among medical personnel; 76% of ministers disagreed that hypnotism conducted by a trained Christian therapist could be safe, while 80% of the medical persons agreed that it could be utilized safely.

**Summary.** Thus, according to these studies, there are differences in the way clergy view mental health disorders, specifically the causes and treatments. Lafuze et al. (2002) found that Methodist clergy endorsed the biological causes over the psychosocial causes, yet acknowledged that all of the biopsychosocial variables contributed to mental illness. This understanding, along with the belief that individual or explicit religious reasons did not play an important role in mental illness, was in line with the general public. However, other studies (Azlin, 1993; Gaston, 2000) indicated that clergy not only embraced the biological and psychosocial, but also the spiritual (demonic influences, spiritual conflict) as possible causes. These were in line with other studies with Christians. The most striking results were the differences Koller (1994) found in her study between Charismatic clergy and Charismatic medical professionals. These clergy endorsed the belief that sin was a cause of mental illness, including alcoholism, and anxiety and panic were the result of not trusting the Lord. This indicated that Charismatic/Pentecostal clergy held different beliefs than clergy of other faith traditions.

In regard to treatment of mental health disorders, the studies indicate that some clergy believe there can be successful collaboration between mental health professionals and clergy, support the use of secular therapies (including prescription medication) in combination with faith based therapies, and prefer to refer to Christian mental health professionals (Azlin, 1993;
Gaston, 2000; Lafuze et al., 2002). These studies supported other studies where Christians held similar beliefs. Once again, Koller’s study with Charismatics revealed that the Charismatic clergy believed that traditional treatments for mental illness were not compatible with Charismatic Christian beliefs, that they should not seek help from non-Christian mental health professionals, and that mental health disorders could be treated by religious practices.

**Summary regarding beliefs.** The literature on the beliefs regarding causes and treatments of mental health disorders indicates that religious culture does play a role in how groups of people view mental illness. Over the years, the American public has embraced more biological and social/circumstantial causes for mental health disorders and less individual/moral causes. Yet, the studies with Christians indicated that they have embraced not only biological and circumstantial causes, but also individual factors. However, the Pentecostal Christians display an interesting difference from the general public and most of the Christian studies. They endorsed the biological and circumstantial, but also highlighted the spiritual (as opposed to individual/moral factors) as cause for mental illness. Specifically, Pentecostal Christians acknowledged forces outside of one’s control as factors, namely demonic possession. This supports the idea that Pentecostal’s spiritual worldview greatly contributes to their understanding of mental illness. The one exception to this was Koller’s study where Charismatic clergy believed that sin and not trusting the Lord contributed to mental illness. Other clergy endorsed the biopsychosocial causes along with the spiritual.

In regard to treatment of mental health disorders, the American public has endorsed a variety of treatments, with an increase in willingness to seek professional help. These include family and friends, physicians, mental health professionals, clergy, and medication. Christians, including Pentecostal Christians, have also acknowledged secular mental health treatment
options including medication, mental health professionals, and psychiatrists. Yet, they also advocate for faith based treatments to be included and prefer treatment by like minded Christian professionals before secular mental health professionals. Once again, the studies with the clergy found similar results, with the exception of the Charismatic clergy in Koller’s (1994) study. The Charismatic clergy supported treatment with like minded professionals and only religious practices.

Given these findings, it is evident that Pentecostal Christians’ complex view of mental health disorders entails a dimension often left unconsidered by the general public, as well as other Christian faith traditions: the spiritual. This supports the assertion that their worldview of embracing the spiritual in their everyday lives plays a significant role in the way they understand mental health disorders. Specifically, they believed in the spiritual component to be the causes of some mental health disorders, and expected faith based treatments to be included with traditional treatments. In addition, Koller’s finding that Charismatic clergy held different beliefs than Charismatic medical professionals is significant.

**Research Plan**

This study employed a qualitative research design, specifically the use of semi-structured interviews by means of telephone interviewing. This method was chosen for a variety of reasons including:

1. Qualitative research methods are useful “in understanding how individuals understand their world” (Krathwohl, 1998, p. 225). This study sought to gain an understanding of how Apostolic Pentecostal clergy perceive mental health disorders in the context of their unique spiritual worldview.
2. Qualitative methods are useful in exploration (Krathwohl, 1998). Apostolic Pentecostal clergy have not been the subject of many studies. This study sought to explore their thoughts, opinions, feelings, and meaning making regarding mental health issues.

3. Qualitative methods are helpful when seeking in depth and detailed information (Krathwohl, 1998; Patton, 2002). This study sought to gain in depth information on the Apostolic Pentecostal clergy’s beliefs regarding the causes and treatments of mental health disorders and how the working of Holy Spirit fits into their understanding. Also, this study sought to gain detailed information about their current counseling practices and interventions they have found helpful when ministering to people with emotional problems, as well as, specific issues that they encounter within their churches.
Chapter Two—Research Methodology

Research Design

This study employed semi-structured interviews only. Interviews use “open ended questions and probes” and yield in-depth responses about people’s experiences, perceptions, opinions, feelings, and knowledge. Data consist of verbatim quotations with sufficient context to be interpretable” (Patton, 2002, p. 4). By using semi-structured interviews, useful information could be obtained regarding their perceptions, feelings, beliefs, etc. about mental health issues. Telephone interviewing allowed for the researcher to record the interviews and interview clergy from outside the immediate area.

Guiding questions. The following demographic and open-ended questions served as the guide for gathering the Apostolic Pentecostal clergy’s perspectives on causes and treatments of mental health disorders, as well as their current practices:

- Are you male or female?
- What is your age and race?
- What organization is your minister’s license from? How long have you been a licensed minister? Were you ever licensed through another organization? If so, which one?
- What is your title? (Bishop, Senior Pastor, Assistant Pastor, Youth Pastor, Evangelist?)
- How many members do you have in your congregation? How would you describe the socioeconomic makeup of your congregation? In what state is your church located?
- What kind of training have you had to prepare you as clergy? What kind of training have you had in counseling and/or mental health issues?

- What types of mental health issues have you seen in your members? What kinds of symptoms/behaviors did they exhibit?

- What are the causes of these mental health issues? What are the causes of other mental health issues?

- How should these mental health issues be treated/resolved?

- What are the roles of clergy, the Holy Ghost, and mental health counselors in treating these mental health issues?

- Do you counsel with church members who are experiencing mental health issues? Why or why not?

- If you have worked with parishioners with mental health problems, what types of interventions have you used to address these mental health issues?

- Have you ever referred a member to a mental health counselor? What characteristics of a mental health counselor would be needed in order for you to feel comfortable with such a referral? What kinds of problems/issues would initiate a referral? Are there any types of problems that you’ll never send to a mental health counselor?

- What would be important for a mental health counselor working with an Apostolic Pentecostal Christian to know?

- Would you collaborate with a mental health counselor in meeting these needs? What would this look like? What might a mental health counselor do that would likely “turn you (and your parishioners) off?”
These open-ended questions served to guide the semi-structured interview. These questions allowed the clergy to express their perspectives on the causes and treatments of mental health issues, as well as gave them an opportunity to discuss the expected roles of the Holy Spirit, clergy, and mental health professionals in treating mental health issues. These questions also addressed the three components of beliefs and practices in a culture’s illness interpretation identified by Sussman (2008) including the conceptual, personnel, and behavioral aspects of interpretation.

**Field sites.** The interviews were held via telephone. Thus, the clergy were able to participate while in the place of their choosing. The interviewer conducted the interview in her home office, without any observers, assuring the privacy of the interview. The interviews were audio recorded to allow for appropriate data collection strategies.

**Purposeful sampling plan.** This study focused on Apostolic Pentecostal clergy. The criteria for selecting participants stated that the interviewees must be an adult over the age of 18 and be licensed as a minister by a recognized Apostolic Pentecostal organization.

**Participant profile.** Six males and one female participated in the study. The participants were licensed ministers and represented four Apostolic Pentecostal organizations. Six participants were Caucasian and one participant was Native American. They ranged in age from 33 to 59 years of age. All participants were married. Participants were from various states within the United States (Connecticut, Indiana, Ohio, Texas, and North Carolina) with a variety of congregation sizes (ranging from 40 members to 750 members). Six participants held bachelor’s degrees: five in theology and one with an associate’s degree in theology and a bachelor’s degree in business management. Three participants were currently pursuing master
degrees. One was pursuing a master’s degree in theology; another was pursuing a master’s
degree in human services; one was pursuing a master’s degree in organizational management.
One participant did not hold a college degree. Pseudonyms were used throughout the narration
to conceal the identity of the participants.
Table 2.1

*Participant Profile*

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Note: Names are pseudonyms given by the researcher. An asterisk designates a degree in progress.
Data Collection Strategy

The research design utilized telephone interviews using open-ended questions in order to explore in depth the Apostolic Pentecostal clergy’s perspectives on mental health issues. The Information Sheet stipulated that the interviews were via telephone and would take between 30 to 45 minutes, and would be recorded for maximum data collection. The actual average length of time for the interview was 60 minutes. The participants reported that they were surprised that they had so much to say about mental health. The interviews were transcribed to assist in analyzing the data.

Gaining entrée. Emails were sent to potential Apostolic Pentecostal clergy participants. These emails were accessed via social media and online websites known to the researcher. Having attended an Apostolic Pentecostal Bible College, as well as being personally involved in the Apostolic Pentecostal faith tradition for more than 30 years, the researcher was aware of potential participants. Although this may have led to potential researcher bias, this was the best way to gain access to this population. Serrano (2003) asserts that the sanctification in the Pentecostal perspective “by definition creates an insider-outsider mentality, drawing firm distinctions between those who belong to the group and those who do not” (p. 223). As such, the researcher’s status as an insider allowed the researcher to gain a number of willing participants who trusted her motivations, her handling of confidential information, as well as her ability to interpret the data within the cultural context.

Emails were sent to potential participants and included the Information Sheet outlining the details of the study. The researcher was available to answer any questions the potential participants had prior to their commitment to be available for consideration. Participants were able to refer other clergy who they thought might be interested in participating in the study. One
Apostolic Pentecostal Clergy

participant was recruited from another clergy member who was a potential participant. Potential participants responded to the recruitment email. The researcher verified eligibility and then scheduled the interview for the time and day best for the minister. The researcher then called the participant.

Data Analysis

This study contained only interview data. This was a semi-structured interview where the literature review provided the guidance for the creation of the questions. Thus, the questions from the interview generated the initial categories of data. These included issues, beliefs regarding the causes of mental health disorders, beliefs regarding treatments of mental health disorders, clergy interventions, role of clergy, role of the Holy Spirit, role of mental health counselors, referral practices, preferred characteristics of mental health counselors, important information about Apostolic Pentecostals, and collaboration. Yet, as the data were collected, and an understanding of the main concepts within the categories emerged, additional categories were added. In this sense, an editing analysis style was used as is often seen in qualitative research (Marshall & Rossman, 1999).

Three levels of coding were applied. First, coding was mostly descriptive and was used to get an idea of the information that was given. The transcription provided this foundation using the participants own language. Secondly, the aforementioned categories within the questions were used to group the major ideas together according to relatedness. Within this analysis, additional themes emerged that were not part of the original categories based on the structure of the interview. For example, one theme that emerged from all of the participants was the idea of the importance of viewing mental health within the context of the whole person. Another theme that emerged was that regarding healing. In the third instance, trends were identified based on
the principle of triangulation that compared data across participants. In order to achieve triangulation, attention was given to the issues identified and discussed by all the participants. The issues that were not discussed by all the participants were treated as secondary issues.

In the initial coding, the language used was that of participants; in the second coding, the language and terms used were still those of the participants but with summarizations. According to Krathwohl (1998), it is important to make use of the participants’ language as much as possible when choosing the titles of codes. In the third coding, the researcher’s professional judgment was used to identify the trends.

In the discussion section, the data were compared with the existing literature and interpreted using the framework presented in the literature review including the importance of religion as a cultural variable, meaning making within the ecological counseling perspective, the context of the Pentecostal worldview, and other studies regarding beliefs of the causes and treatments of mental health disorders.

**Reliability and Validity**

To ensure reliability and validity, member checking was utilized. Member checking refers to the researcher verifying with the respondent the meanings that develop during the course of study (Krathwohl, 1998). The researcher discussed with participants the conclusions that were drawn from their responses. The researcher informed the participants how she understood their answers and asked if the conclusions were correct. In addition, triangulation of sources was used in order to confirm themes and categories. This was accomplished by checking consistency between interview participants (Patton, 2002).
Limitations

This was an exploratory study. Seven interviews were conducted. A larger number of participants would be needed to make assumptions about the population as a whole. Thus, the study was limited in its scope. In addition, there could be some researcher bias due to the researcher being identified with the culture being studied.
Chapter Three-Data Narration

The narration begins with a brief description of each participant in the study based on the information provided by the following demographic questions: “Are you male or female?” “What is your age and race?” “What organization is your minister’s license from?” “How long have you been a licensed minister?” “Were you ever licensed through another organization?” “If so, which one?” “What is your title? (Bishop, Senior Pastor, Assistant Pastor, Youth Pastor, Evangelist)” “How many members do you have in your congregation?” “How would you describe the socioeconomic makeup of your congregation?” “In what state is your church located?” “What kind of training have you had to prepare you as clergy?” “What kind of training have you had in counseling and/or mental health issues?” (Appendix C, questions 1 through 6).

The rest of the narration is arranged in categories in accordance with the questions in the interview guide. This was done since the data were collected using a semi-structured interview. Themes within the categories are arranged as subheadings. First, the responses to the questions, “What types of mental health issues have you seen in your members?” and “What kinds of symptoms/behaviors did they exhibit?” are reported (Appendix C, question 7). This category is labeled Mental Health Issues. The mental health issues that the participants indentified in parishioners are described. Within this category was a theme described as Understanding of Mental Health.

Second, the responses to the questions, “What are the causes of these mental health issues?” and “What are the causes of other mental health issues?” are discussed (Appendix C, question 8). This is labeled Beliefs Regarding Causes of Mental Health Disorders. The clergy
attributed mental health disorders to a variety of causes, including biological and circumstantial. The theme that emerged within this category is entitled *Multiple Causes*.

Next, responses from the question, “How should these mental health issues be treated/resolved?” are shared (Appendix C, question 9). This is labeled as *Beliefs Regarding Treatment of Mental Health Disorders*. Several themes in this category of treatment emerged and include (a) *Counseling, Medication, and Concurrent Spiritual Care*, (b) *Treatment Should Address the Whole Person*, (c) *Mental Health Care Works With Spiritual Care in a Healing Process*, (d) *God is Involved in Healing*, and (e) *Preference for Christian Mental Health Professionals*.

Next, responses to the question, “What are the roles of clergy, the Holy Ghost, and mental health counselors in treating these mental health issues?” are shared (Appendix C, question 10) in three separate categories. These categories include *Clergy Roles in Treatment*, *Role of Holy Ghost (Holy Spirit) in Treatment*, and *Mental Health Counselor Roles in Treatment*. The answers to the questions, “Do you counsel with church members who are experiencing mental health issues? Why or Why Not?” (Appendix C, question 11) and “If you have worked with parishioners with mental health problems, what types of interventions have you used to address these mental health issues?” (Appendix C, question 12) are shared within the category *Clergy Roles in Treatment*.

In the category *Clergy Roles of Treatment*, the theme of *Spiritual Care* is shared with the subtheme of *Interventions* (divided into *Supportive techniques* and *Faith-based techniques*). Also, the themes of *Evaluate the Problem, Refer to Mental Health*, and *Be Led by Holy Spirit* are identified. In the category, *Role of Holy Ghost (Holy Spirit) in Treatment*, the theme of *The Presence of God as an Active Helper* is described. In the category of *Mental Health Counselor*
Roles in Treatment, themes shared include Mental/Emotional Care and Works Together With Clergy.

Subsequently, the responses to the questions, “Have you ever referred a member to a mental health counselor?” “What characteristics of a mental health counselor would be needed in order for you to feel comfortable with such a referral?” “What kinds of problems/issues would initiate a referral?” “Are there any types of problems that you’ll never send to a mental health counselor?” (Appendix C, question 13) are described. This is labeled as Referrals to Mental Health Counselors. The subheadings in this category are Preferred Characteristics of Mental Health Professionals, Problems That Clergy Would Send to Mental Health Counselors, and Problems That Clergy Would Not Send to Mental Health Counselors.

Next, responses to the question, “What would be important for a mental health counselor working with an Apostolic Pentecostal Christian to know?”(Appendix C, question 14) were shared. This category is identified as Important Things for Counselors to Know About Apostolic Pentecostal Christians. Themes presented within this category are Faith-based Spiritual Worldview and Impact of Past Teachings on Perceptions.

Finally, responses to the questions, “Would you collaborate with a mental health counselor in meeting these needs? What would this look like? What might a mental health counselor do that would likely ‘turn you (and your parishioners) off’?” (Appendix C, questions 15). This was labeled as Collaboration with Mental Health Professionals. Subheadings within this final category are Clergy Views of Collaboration and Things That Would Likely Turn Apostolic Pentecostal Clergy and Parishioners “Off”.
**Participant Descriptions**

“**Alan**”. Alan is a 33-year-old married Caucasian male who has been a licensed minister for 12 years. He is the senior pastor of two churches in Indiana. One congregation has 75 members and one has 25 members. The majority (90%) of the members are Caucasian, with the remaining 10% being African American or Asian. The church has a broad age range of newborn infants to people in their 90s. They are in the lower to middle class.

Alan holds two bachelor’s degrees: one in theology; the other in Biblical Literature, Biblical Languages, and Sociology. He is currently pursuing a master’s degree in Theological Studies. All three of the schools he attended are affiliated with Apostolic Pentecostal organizations. In addition, he was a police chaplain in a large city for six years and completed a 15-week course in crisis management and crisis counseling through the police department. As a police chaplain, he provided spiritually based crisis counseling to families at crime scenes involving loss and trauma. He also provided counseling to the first responders as well as prison inmates. He is the president of an interdenominational ministerial association in his city and completes ongoing continuing education in pastoral care on a regular basis. He also reported that he reads a lot independently. The researcher met Alan while attending the same Bible college.

“**Bob**”. Bob is a 52-year-old married Caucasian male who has been a licensed minister for 26 years. He is the senior pastor of a church in Ohio with 50 parishioners. About 90% of the congregation is Caucasian and 10% is African American. The members are in the middle class.

Bob has a bachelor’s degree in theology from an Apostolic Pentecostal college. He had a few classes related to counseling while in college and has taken a few continuing education seminars. The researcher has never met Bob. She went to church in the past with his son-in-law who referred him.
“Claire”. Claire is a 59-year-old married Caucasian female who has been a licensed minister for nine years. She is an evangelist who focuses on women’s ministry. The current congregation she attends is in Texas and has 400 members. The congregation is described as middle class with a mixture of ethnicities. These include mostly Euro Americans, with some Hispanic, Korean, and Indian ethnicities. The average size of the congregations she ministers too around the country range from 150 members to 400 members.

Claire did not attend a Bible college and does not have a college degree. She did attend a community college. She entered the ministry later in life, as a second career. She reported that her training for the clergy has been studying under and being mentored by other ministers, independent study, conferences, leadership seminars, work experience, and life experience. She reported that she has taken a couple of classes in psychology. The researcher met Claire recently through their connection with an Apostolic Pentecostal organization.

“Dan”. Dan is a 52-year-old married Caucasian male who has been a licensed minister for 29 years. He is the administrative pastor for a church in Texas, with 750 members. He described this congregation as middle to upper class with a diverse racial makeup. The church is comprised of approximately 65% Euro American, 20% African American, and 15% Hispanic.

Dan holds a bachelor’s degree in theology from an Apostolic Pentecostal college. In addition to this degree, he has taken some counseling classes and has done independent study. He reported that his experience over time has also prepared him for ministry. The researcher was a member at various times of a congregation that Dan formerly pastored.

“Evan”. Evan is a 41-year-old married Caucasian male who has been a licensed minister for 17 years. He is the pastor of a congregation of 30 to 40 members in North Carolina. It is made up of mostly Caucasians who are in the lower middle class.
Evan has a bachelor’s degree in theology from an Apostolic Pentecostal school and is pursuing a master’s degree in human services from a Christian University. He reported that until his studies within the master’s program, he only had a handful of counseling related classes while in Bible school. He has attended various conferences and seminars for ministers. The researcher has never met Evan. The researcher met Evan’s wife several years ago while attending Bible College.

“Fred”. Fred is a 40-year-old married Caucasian male who has been licensed as a minister for 18 years. He is the senior pastor of a church in Ohio, with 350 members. The parishioners come from a variety of backgrounds. Fred reported that they are extreme poverty level to upper middle class, with a broad age range. They are mostly Caucasian and about 20% African American, with a few individuals from other minorities.

Fred has a bachelor’s degree in theology from an Apostolic Pentecostal school. In addition, he has eight years of experience as an evangelist and counts his 18 years of full time ministry as part of his training for clergy. He reported taking three classes related to counseling while attending Bible school. He also reported that he reads independently as ongoing education. The researcher met Fred over 20 years ago through a connection with an Apostolic Pentecostal organization.

“George”. George is a 41-year-old married Native American male who has been licensed as a minister for 20 years. He is the senior pastor of a church of about 150 members in Connecticut. He reported that the congregation is very diverse, with a broad age range and range of educational levels, including bachelor’s degrees and a handful of members with master’s degrees and doctorates. The church is comprised of 50% Jamaican and 50% of a
combination of Euro American, Hispanic, African American, West Indian, Native American, and Asian American.

George has an associate’s degree in theology from an Apostolic Pentecostal college, a bachelor’s degree in business management, and is pursuing a master’s degree in organizational management. In addition, he took trainings offered at a local church, as well as other educational seminars at various churches. Also, he reported having a few classes in counseling and counted experience over the years as preparing him for clergy. The researcher has never met George. The researcher met George’s wife while attending Bible school.

**Mental Health Issues**

The clergy were asked, “What types of mental health issues have you seen in your members? What kinds of symptoms/behaviors did they exhibit?” The clergy members interviewed identified a variety of issues that they have seen with members who have been part of their congregations. These included hopelessness, psychological and emotional issues related to job loss, marriage and family problems, issues related to menopause, stress that is both good and bad, anxiety disorders including general anxiety and panic attacks, mood disorders including depression and bipolar disorder, personality disorders including borderline personality disorder, problems in thinking and reality testing including schizophrenia, substance abuse disorders including alcohol and other drugs, autism, and issues related to trauma and abuse.

**Understanding of mental health.** A point of interest was that when some of the clergy members were asked the question, “What kind of mental health issues have you seen in your members?” they understood the question in the context of issues that were specifically related to mental functioning, in the literal sense of the word. That is, they identified those issues they
associated with dysfunction in cognition. When the researcher asked if they knew of any issues that were emotional or related to feelings, they identified more issues.

For example, Evan first responded,

Two that really stand out…one that is living in a group home. He has mental issues which keeps him from thinking straight, can live on his own. He is paranoid. He has what they call fast talking. I didn’t diagnose him with that. I was told by a mental health professional…fast talker, just rambles on, his sentences do not connect. He will say one thing and go on to a new thing. I am very confident in saying a pastor has no idea how to deal with that…He needs medication. He needs help…paranoid…thoughts don’t connect. He is very hard to follow…needy…calls a whole a lot.

Evan went on to talk about another individual who had obsessive behaviors and phobias, but said he did not know if that was “mental”. He said,

Other guy, good guy…few years younger than I am, is married has children…He doesn’t like large crowds. He can’t talk to people. He doesn’t want to be away from the house. When he is there, he doesn’t lay down, gets up, looks out the window, lays back down, gets back up. He is not a very good communicator. He will walk away and repeat it and it is not what you said. He takes things the wrong way. I don’t know if that is a mental, very slow to say that, but maybe it is a personality disorder, you know. To choose to not live on some land is one thing; to choose not to live in a subdivision, I get that. But, it makes him very nervous. He doesn’t like crowds. He didn’t go to his high school graduation. He didn’t go to his college graduation…too big crowds, life events things like that…He is taking medication for it as well.
When the researcher asked if he had seen any other issues that were emotional or related to feelings, he identified a woman who had suffered abuse as a child and had symptoms of depression. In addition, he talked about seeing family issues and ways of interacting with others because of poverty.

Fred responded in like manner,

You know, we pick up some people from a group home that is only a mile from us or so. We bring some of those in a van…We’ve got an autistic boy that …everybody just loves. He kind of sits on the back row and jumps around quite a bit. Every once and a while he will come up and everybody just knows him and he will sometimes even come up at altar service and take a microphone and sing. We will turn the microphone off and he will hold it…I am trying to think. I don’t know if we have a lot. But, just a handful of cases like that in our church…is probably the only one that stands out. Like I said, he will kind of jump around, blurt out once in a while…Jackie comes from the group home. She is probably…I don’t know what her disability would be. She is a little bit slow…

When the researcher followed up by asking about any issues that were emotional types of issues, Fred, like Evan, identified additional issues. He discussed being aware of people with mood swings and depression.

Dan had similar responses. His interview was conducted prior to Evan and Fred’s interviews. He identified a variety of issues that had more than a cognitive component, but he related them to the “mental” or of the mind. His response to the question was,

Bipolar, schizophrenia…personality disorders…Those are the main ones, there are probably minimal issues that we have dealt with that has happened with us but that would be more of a stamp that you can put on most of it…that I have dealt with.
When asked if he had seen any other “mental health or counseling issues”, he still viewed them in the context of cognition, “…people think they have a demon as opposed to…They have voices in their head telling them to do certain things. They don’t know if it is God talking to them, or the devil, or themselves.” He continued with this understanding throughout the interview. The researcher thought that he was distinguishing between severe mental illness and mental health issues and asked the same question at different times throughout the interview. However, it was not until later in the interview that the researcher realized the problem was in the word “mental”. (Dan was operating under the understanding that a mental health counselor was different from a professional counselor.) This led the researcher to see that he was viewing “mental” health in the literal sense and thought the researcher was specifying disorders affecting cognition. Once the researcher explained that the general term “mental health” encompassed all mental/emotional issues, he included those issues as well. (He identified emotional issues related to abuse, depression, divorce, anger, etc.) Due to this discovery, the researcher was able to recognize this perception in the subsequent interviews of Evan and Fred and reworded the question.

When the clergy members described the symptoms and behaviors associated with the mental health issues, they were congruent with the clergy’s descriptions of the issues. The symptoms included cognitive, emotional, and behavioral descriptions. For example, when Claire discussed anxiety, she correctly identified symptoms of panic attacks as the person feeling like they were having a heart attack or that they were going crazy. When Dan, George, and Evan talked about people with schizophrenia, they described problems in reality testing, cognitive dysfunctions, communication difficulties, paranoia, and auditory hallucinations.
Beliefs Regarding Causes of Mental Health Disorders

**Multiple causes.** The clergy endorsed a variety of causes to the mental health disorders including biological components, life circumstances, family environments, and individual differences. Only one person mentioned drugs and alcohol. The clergy discussed spiritual factors in terms of past beliefs, rare occurrences, and not as primary causes for mental health issues. All endorsed more than one cause for mental health issues and some shared that they did not really know what caused some of the mental health issues. They realized that there could be multiple causes, depending on the issue and the individual, and most of the time there was more than one contributing factor to mental health issues.

Claire stated,

I think it is all of those. I think it is very difficult in the mental health field. To me, it would be very difficult to say-- to pinpoint and say--this is what caused this mental illness. I think you can have some generality but to me every person is different because we are all individuals. We are all made up differently.

Claire reported that people could experience mental health issues due to stress related to...life events...usually it is not just one life event. It is different: a change in job, changing where you live, going from one state to another state, changing everything that you know and are familiar and comfortable with. It can be a series of events over several years. It may just be a buildup...over a period of time, which could be several years. One thing is added on. Eventually it is the straw that breaks the camel’s back. It doesn’t have to be anything huge in that person’s life...just a stress. Of course stress can be good and bad and they both affect us as people. So, if you just have that one small thing, that can add that...can be that straw that puts you over the edge.
She went on to state that it was multiple stressors in life and could simply be daily events such as families, careers, and being busy, and those things catching up to people who do not take “down time” for themselves. Claire talked about how bad things can happen to some people and they can handle it and make good out of it, while others cannot. She reported seeing individuals with families with generations of mental illness and reported that the individual could have inherited his/her biology from the family, or simply learned the family patterns, or had some combination of the two. She also acknowledged the individual biology of the person; once again, as noted before, that everyone is made up differently.

Claire noted that this was a change from centuries past, especially in the religious world. She said that in the past there some people could have thought that a person was “demon possessed” or could “have a spirit that they needed to be delivered from”. She noted that she believed the church world had progressed. And although she still believed in the possibility of demonic forces, it was something that she saw more in her international travels, and not something that she has typically seen in the United States. She said,

I don’t think that is it for the most part… I think that it is something that is connected in the brain. You know, it can be something that is not formed correctly, something that is just misfiring… I think demon possession can happen. I know it does. I think it hides itself well in the United States. I think we are a sophisticated country. However, that won’t necessarily be my first thought because we see too much that is going on that is not that. We need to be very careful and look at all of the possibilities. I think for the most part it is usually a disconnect in the brain or something in the way it is formed. All these variety of issues come into play.
Similarly, Dan stated that some mental health issues were caused by chemical imbalances; some were caused because of the effects of being abused as a child; and others were born that way. He acknowledged, as Claire did, that he did not know all the reasons that cause people to have mental illness; he could only report want he had personally observed. He reported that people had not shared details of their past to enable him to make those decisions. He said, “People are simple minded and they cannot help it. It is just the way they are born.”

He also shared that,

If someone has been abused mentally growing up, they have certain concepts about themselves that people have instilled in them and that affects them…mentally…what they think of themselves, how they handle themselves, what they think of other people…

He went on to say mental health issues could also be caused by

…things they are going through in life, their childhood, they have lost their jobs,
sometimes spouses have left them, divorce, a lot of reasons… and sometimes it can be a chemical imbalance. I have found more often than not, it is something else affecting them …There are a number of things…

Moreover, while Dan informed the interviewer that he had members in the past with severe mental illness (bipolar disorder and schizophrenia) that had come to him and thought they had a demon in them, he gave no indication that he believed this was the cause for their mental illness or mental health issues as a whole. He reported that he had members who had …difficulty separating what is real and what is dreams or thoughts, as opposed to…they have voices in their head telling them to do certain things. They don’t know if it is God talking to them, or the devil, or themselves…
Likewise, Alan endorsed a variety of causes for mental health disorders including the ramifications of abuse, and major life happenings such as divorce, death of a loved one, and loss of a job. He said that sometimes it is simply life. He reported that,

I have been dealing with...recently someone who had been in the ministry; her and her husband got divorced. Right after she divorced, she got pregnant and now she has a teenage daughter who just got pregnant. So, there is a lot of different things that we are dealing with there, trying to work with this person. So, it’s divorce, compounded by out of wedlock pregnancy, compounded by a few years later...out of wedlock teenager having a baby. So, there is a lot issues there. There can be a lot of things that lead to this mental turmoil, for lack of a better term.

In addition to these causes, Alan also acknowledged biological components to mental health issues. He stated,

There are other...one member who is battling with the bipolar and borderline...a lot of that is hereditary. Her mom was that way, her grandmother was that way, and so it is something that has kind of been passed on generation to generation...A lot of them were biological and hereditary issues...

In similar fashion, Bob also believed mental health issues are caused by a variety of factors including the affects of abuse, family environments and the way the child was raised, genetics, and chemical imbalances. He noted that his endorsement of chemical causes was a change in his past understanding of mental health issues. He remarked,

I believe that there are some people who chemically struggle with thinking...I believe there are two ways. Thinking changes the chemistry in your body. I believe that your
chemistry can change your thinking. I believe both of them. And I believe that some people can have chemical problems.

He also noted that,

…we are a makeup of our parents and it is amazing to me how a father and a mother can be so good with their thinking, but the child…might be born with a handicap…it comes out of the same genes.

He later asserted, “I have been in the ditches with people that I realize, once again, there is a chemical imbalance along with the psychological imbalance.”

Bob did not specifically bring up the topic of demons or evil spirits. The researcher asked his opinion during the course of the interview. He informed the researcher that he did believe that demon possession could occur (only if a person was willing), but believed it was something that rarely occurred. He reported that in his thirty plus years of personal ministry, he had only dealt with it twice. He said that devils are not something that one goes looking for, but God does make provision for deliverance. He asserted that evil spirits are not viewed as a cause for mental health issues.

Evan also attributed a variety of causes to mental health disorders and expressed some uncertainty about the causes. He mentioned the emotional issues that result from job loss and generational poverty, as well as abuse, family patterns, and the biological, which he termed “medical”. He said,

I think if it is mental health…beyond their way of thinking…beyond their upbringing…I guess it is more of a medical thing. Wouldn’t that be more of a medical diagnosis? The man that I talked about being paranoid…and a fast talker…His mind is not right. That is one thing…Causes…I guess if it is a mental issue…a true mental issue…you know what
I mean…not being funny…but they went crazy or they were born with some mental deficiency…You know the reason for that…something happened…nervous breakdown…from pressure they lost their mind. I am not sure if I am saying that right.

This was given as an example of a biological cause. On the other hand, Evan also said that there could be other causes, including someone that just did not have the coping skills to be able to deal with life or someone who experienced a mental health issue like depression because of poor life satisfaction.

Evan did not specifically bring up spiritual factors when the question was asked about causes. However, later in the interview he acknowledged that in the past he had mistakenly thought things related to the mind were just spiritual problems. He said, “I vehemently disagree with my own words from twenty plus years ago”. He equated mental health issues with being sick in other parts of the body, something that he did not understand in that way when he was younger.

George, like the others, embraced both biological and environmental dimensions. When asked about causes, he replied,

I think there are many that are caused by chemical imbalances. I think there are many that are caused by the family environment that someone grew up in. I would say those two are probably the two biggest…being passed on through a family environment…to call those hard coded genetic…through blood DNA. I think it is more the environmental. I think that can be passed on generationally…As far as the root cause, I would say those two are the biggest and sometimes those both come into play.

In addition, he acknowledged that abuse or other trauma could cause mental health issues.
As the others had stated, George did not believe there were spirits that caused mental health issues. He stated that,

Over the long course of time, a spiritual element could be added in, but I don’t think that is a part of the original cause in the cases that I have seen. But I think over the long course of time, that spiritual issues could attach themselves to the physical conditions whether it is a chemical imbalance or the family environment…

This supports the belief that mental health issues can often affect a person’s spiritual functioning.

Finally, Fred, like many of the others, said that he did not know or have any idea what caused mental health issues and embraced diverse causes including chemical imbalances, abuse, past hurts, and traumas. He acknowledged the chemical by saying, “I do believe there are very real chemical imbalances and things in their body and we know that sometimes the medicine does help.” He then later gave the example of his wife’s poor reaction to hormonal birth control and the effect it had on her emotions. He also discussed his observations of someone with a mood disorder and commented,

…there is an aspect of it that there is some sort of chemical imbalance and you just know just watching people and their mood swings. They will be fine one minute and not fine the next. It is hard not to imagine there is not some kind of chemical reaction. I don’t know if that is the right terminology. But I guess you know what I mean…just people naturally just have some kind of chemical imbalance that I think definitely lends itself to emotions…

Simultaneously, as others, he endorsed life circumstances and asserted,
I feel like a lot of this stuff, first and foremost, is people have been hurt somewhere in their past, something they have gone through. It is not some kind of spiritual thing. It is just we are emotional people and there are hurts that people just don’t ever get over. And that is I would say is the number one cause…something tragic, maybe someone who was molested as a child and just locked that up inside…or something simple as a misunderstanding that people have let become a wound or a hurt. And I think that is what happens a lot of times.

He went on to say when specifically addressing causes for depression,

I think weighing a cause…very few of us are living our dream and life has not turned out the way we thought and I think that tends to compile on people… sometimes I think people look at their life and think ‘I don’t think I can ever get my life where I wanted to as a kid. You know I’ve been through a divorce and I have been through this and that. And this is not how I pictured my life and there is no way I can ever have the picture I had in my mind.’ I think that is one of the reasons, one of our causes.

In addition, like some of the others mentioned, Fred discussed his belief that it was possible for “demonic spirits” or “spirits” to “attack people” but that it was rare and was not seen as a common cause for a mental health issue. Like Claire, he had observed this when he traveled outside of the United States but stated that he did not think it “is nearly as prevalent in America as in other places”.

The only one that mentioned drugs and alcohol as a potential cause for mental health issues was Bob. He specified that drugs and alcohol were the cause of addiction issues. He also identified drugs in the sense of those that have been manufactured by the medical community and their possible side effects.
Beliefs Regarding Treatment of Mental Health Disorders

All of the clergy endorsed professional counseling and medication as treatment for mental health issues, with concurrent spiritual care. Everyone also indicated that there were some mental health issues that could not be resolved by counseling alone and needed to be treated with medication. They felt a personal responsibility to their parishioners, yet acknowledged that mental health professionals were more equipped and trained to handle mental health disorders. They supported referring mental health disorders to mental health professionals for treatment. They believed that it was important to address the whole person when treating mental health issues and discussed a balance of addressing the physical, mental, emotional, and spiritual aspects of an individual. In addition, an overriding theme of healing was evident throughout the conversations of treatment. The clergy believed that God could heal any type of problem but often times He does not and can use mental health modalities outside of the Spiritual realm to accomplish the healing. Regardless of the process and modalities, God is involved in the healing process.

Counseling, medication, and concurrent spiritual care. When asked how mental health issues should be treated, clergy all agreed that mental health professionals should treat them with counseling and medication; clergy should provide concurrent spiritual care as a support. Dan made it clear that he believed they should be treated by mental health professionals and medication. He replied,

…resolved by professionals. Some of them I feel need medication. Some of them that I really believe are mental health issues I believe…can be helped with counseling but not all of them. I think that some of them are chemical imbalances in the body physically. So even if I am telling them what they need to do and they are listening to me, such as
bipolar people, they have an inability because of the imbalance in their body to be able to
do what I am asking them to do…not all the time, some of the time. Therefore, I believe
they need medication to help regulate that for them. Just as someone with high blood
pressure can try to watch their diet, they might be at a place that just watching their diet is
not going to help. They need some help with medication. Both of those working together
helps that person be able to function. I feel the same way with mental health issues…if I
find it is mental illness, I always refer them to a professional counselor.

Dan felt that he could provide pastoral support, but professionals should handle mental health
issues. He remarked,

…there is a certain amount of compassion and…spiritual guidance that I can give them.

But, to make them completely functional, I feel it is best to refer them to someone who
has had more education in that field and more experience than I do.

He said that if he felt it was mental illness, he always referred them to a professional counselor
because he believed they would be of more help to them than he would.

Alan agreed, that as a pastor, there are mental health issues he is not equipped to handle
and they should be treated by mental health professionals. He stated,

Here you get into some sticky situations because as a pastor, I feel it is my responsibility
to be there for them…for the congregation…for the congregant of our church…to be
supportive and help them in any way that I can. But I also have to realize there are people
who are equipped to take care of these more serious issues, a lot of issues that fall outside
of what I would term pastoral care… And I will let them also know if there are certain
areas that I am just not equipped…I have had more training than a lot of pastors have
had…sad to say…helped me to realize there is a lot I don’t know and there is a lot I am not equipped to handle as a pastor.

Alan discussed referring mental health issues to a professional counselor. Although he had previously acknowledged that there are some mental health disorders that are caused by chemical imbalances and knew individuals that were being treated with medication, he did not directly mention medication when discussing treatment. When the researcher asked his opinion on medication, he agreed with the use of medication in moderation, as part of the treatment of counseling and spiritual care. He stated,

I don’t have a problem with them as long as they are used in moderation and they are not used as an end all. By that, I mean I just don’t want to send them to a doctor, therapist, counselor, and say ‘let’s just dope him up.’ If it is used as kind of a stopgap until the person can help get to their issues or as a gradual process where it can help them through a rough time I don’t have a problem with it. It is when people are basically using that as an escape route. That is when I have a problem with it.

He agreed that he would endorse medication as part of the collaborative treatment of counseling and spiritual care. He supported the use of medication for those issues that had a biological component. He stated that he understood there were circumstances where individuals would need to remain on medication and supported it “as long as it was controlled…with the help of the doctor…as long as it was not done needlessly or simply to control the person…an actual medical necessity.” He continued,

I would look at that the same way I would as a diabetic on insulin. You know. That is something that is necessary because of a biological or physical component to a sickness that they have. I have no problem with that…things like that. That is going to cause some
need for medication. I understand that and I am willing to work with the people on that and work with their counselors…and their doctors.

Evan also believed that mental health professionals should treat mental health issues. He asserted, “…I think a pastor should know what is beyond his profession, his knowledge, for him to say, ‘I think you should go to somebody who could better help you.” He also said that he would easily refer to someone else if it goes beyond what he is trained to handle. He used a similar example as Dan and Alan, advocating for both medication and counseling, when he stated that people could be “be sick in their mind and like some of us can be sick in other parts of the body...and need some medication…or it could be meeting once a week and talking for a while.”

George also believed that mental health issues should be treated with counseling, medication, and pastoral care. He stated that if a problem could not be resolved within about three pastoral sessions, he would refer them to a licensed counselor. He said, …for the most part in my pastoring…I am not licensed as a counselor or mental health professional…so I just feel if it is more than what I can help with in a few sessions, it really needs to go to someone who has some specialized training to help with that.

He believed that some mental health issues required medication. When discussing an individual diagnosed with schizophrenia, he remarked,

I always did everything I could to encourage him to continue to stay on the medication that had been prescribed him. It was such an extreme case. There was such an obvious need for the medication that it was very clear that was the right choice in that circumstance.
In like manner, Claire identified counseling, medication, and spiritual care as treatments for mental health issues. Claire knew of members who had worked with counselors who were very helpful in treating mental health disorders. She discussed encouraging parishioners to go see a counselor or a physician. Claire acknowledged medicine was a treatment option and stated, “You can have a medicine that can help you get to a certain point, so that mentally you can deal with whatever is going on in your life.” Claire saw medication as part of addressing the whole person and indicated that medication could just be for a time. She saw the need for medication if it was needed, she just did not want it to be the only treatment, as Alan had also indicated. She did not counsel with members because she did not feel she had the education to do so. She said that she could provide spiritual support.

Fred also acknowledged the treatment modalities of counseling, medication, and spiritual care. Regarding medication, he remarked,

…and if it is just a chemical thing, if there is a medicine that would help…it says in the Bible that we are given wisdom to invent and create…It is amazing what the medical community can do. And you know if there is a medicine that can help, unless there are just drastic side effects, let’s pursue that option too.”

Fred stated that medicine would be his last resort. But he also acknowledged, “If it is a chemical imbalance, I don’t see where going to a counselor will help. They will probably need to get on the right medicine.” In addition, just as the others mentioned, Fred distinguished between his abilities as a pastor and those of counselors. He stated, “…when I sit down to counsel with someone, I always point out that I am not a licensed counselor. I don’t have a degree in counseling…I am a pastor.”
When Bob was asked how mental health issues were treated or resolved, he said that he did not know if these issues would ever be resolved “because it is such a big mountain”. He acknowledged that mental health issues could be treated with professional counseling and pastoral counseling. Like Alan, he did not specifically name medication as part of treatment. However, he had previously acknowledged that a chemical imbalance could be a cause for mental health disorders. Thus, the researcher asked about his thoughts on medication for treating mental health issues. He replied,

Yeah. I don’t have a problem with medication…I realize, that once again, there is a chemical imbalance along with the psychological imbalance. I believe thinking affects our chemicals and our chemicals affect our thinking….I don’t like to see it be long term but I’ve had people that are close to me that have had to be on medication due to their struggling with depression and anxiety…I don’t have a problem with that. No.

**Treatment should address the whole person.** The clergy stressed the importance of addressing the whole person when treating mental health issues. This included the spiritual, mental, emotional, and physical. Their approval of the three aforementioned treatment modalities of pastoral care, mental health counseling, and medication highlighted this belief. When Claire endorsed counseling, spiritual care, and medication, she asserted,

That the worst thing that we do, that the medical field does in diagnosing people with mental illness is they put them in a box…I think we can see that in society anyway and it is like ‘This is what causes it.’ And we don’t look at the person…I think it is an individual, an individual walk with mental illness…

She advocated for looking at all of the factors that contribute to mental illness, seeing the whole person. She said that we needed to “Look at the whole person and…look at the way they think
…their mind, their body, and their spiritual. I think all three needs to be looked at…I see the value of it all.”

Bob also discussed the significance of treating the whole person and shared how a person was “body, soul, and spirit” and how they were interconnected. He asserted,

We need to take care of the spiritual side just as we take care of the physical side. I believe that the physical side--not taking good care of the physical side--affects the spiritual side. I believe that not taking care of the spiritual side affects the physical side.

Likewise, Dan stressed the importance of treating the spiritual, biological, and mental aspects of the person. He talked about the combination of counseling, medication, and pastoral care as the balanced approach to accomplishing this. Alan agreed that treating the person emotionally, spiritually, and mentally was important. Fred talked about individuals as being composed of the spiritual, physical, and mental/emotional as well. Evan and George also talked about the biological, spiritual, and emotional aspects of members.

**Mental health care works with spiritual care in a healing process.** The understanding that members needed to be considered as whole people composed of the spiritual, physical, emotional, and mental was directly connected to the clergy beliefs regarding treatment and views on healing. To clergy, it was important that members have complete health or wholeness. Complete health meant spiritual, physical, and mental/emotional health. The ministers acknowledged that in the past, many believed that if you were spiritually healthy, then it would follow that you would be emotionally, mentally, and even physically healthy. The clergy interviewed stressed that God could heal individuals instantly of physical, emotional, and mental health issues while healing the spiritual, but often He allows complete healing to be a process. Through a process, individuals could reach a place of total health. The ministers
discussed that part of this process often involves getting help from mental health professionals in addition to the spiritual care.

Dan addressed this early in the interview. He stated that he thought the clergy needed to be aware that mental health issues are real situations that people face. He admonished clergy to be led by God’s Spirit in helping people. He saw part of that as being able to determine that members needed additional help from professionals. He shared,

…Many people think that Christ was all about just healing everyone and really didn’t put a lot of faith in doctors… That seems rather strange to me because one of his followers was a doctor. James was (and He refers to him in that way in Scriptures and so others refer to him as well). So, we follow the Spirit and I pray for people…If I see that myself (in praying with them) is not going to be enough to help them be completely whole, then I would refer them to someone who is a doctor who could help them along. I would hope that the doctor, as well as the Spirit, and myself could work together making them completing whole. Because I believe the word, salvation, is wholeness, completeness. I believe God wants to help us be complete as individuals--whether that is by His healing where we are completely healed without any medication--or He is enabled us to be in contact with doctors…We live in a world that is not perfect. One day …we will have whole bodies. But until that time, He has given us doctors/physicians and counselors and ministers to help us to be as whole as we can while we are in this life.

Later in the interview, he discussed again the importance of balancing the spiritual care and the mental health care with members. He said that it was important for the mental health professionals to acknowledge the spiritual, but it was also just as important for clergy and parishioners to acknowledge the mental health piece. He asserted,
…You have to balance that. What I mean by that is there are some people that feel like they do not feel that they need to be taking medication because God should heal them. I had a lady that I dealt with that I sent to someone and she had mental issues…and she has to take medication to this day…and she takes her medicine and she is fine. She came to me and said she didn’t want to take her medicine and she believed in God. She wanted to trust God to heal her…My response to her is ‘God can heal you and I am going to pray with you that He will. Instead of you not taking the medicine and waiting for God to heal you, you need to take the medicine until God does heal you. That way you can function for your family.’ I didn’t derail her believing in God. I think the counselor has to be sensitive to that. We are not saying God can’t do this. We are not saying that God won’t do this. But until God does it…this is what we are going to do. And we are working together on this. I think you have to be balanced so they are not just putting all their faith in that God is going to do it. All or nothing…There has to be a balance.

He continued,

In the past, Apostolic Pentecostal ministers as a whole, not complete, but majority, have looked away from professional counseling and felt like all people had to do was pray through and get a real touch from the Spirit and they would be ok. They have found out long term that was probably not the best route to go…I see more and more Apostolic Pentecostal ministers opening up and helping people understand there needs to be a balance in that. It is not all of one and none of the other…and all of the Spirit, and none of the other. It is not all of the counseling, and none of the Spirit. It is a balance. I have seen more ministers moving toward that and have seen a bit of success with helping people do that.
Alan shared the belief that parishioners could need more help beyond the spiritual care. He commented,

Sometimes I realize that a place of spiritual help is not always a place…I am not knowing how to phrase this… Sometimes they need help beyond…where they get to a place where they are spiritually right. Sometimes it takes some outside help to get them to a place where they are on a firm footing emotionally, psychologically. So really, I think it takes the pastoral care and outside help working together with that person. The Holy Ghost works all of this together. I think it has to be a hand-in-hand working together to get a person to a place of total health emotionally, spiritually, psychologically. It kind of all has to work together because they--especially the pastor and the outside counselor--are working on two different areas and it is in the same person.

He went on to talk about how many times a person is transformed spiritually, but they continue to carry “baggage” with them. He explained that many times it is things from their past that they need to work through themselves. He said,

…and sometimes those things can weigh on a person’s life and spirit and need some outside help with that. A lot of that falls under pastoral counseling but sometimes it can lead to deeper issues that they are needing to work through. I have had in the past, working with people who have been molested, and things like that, there are a lot of issues there…They are filled with the Spirit, but there is still a lot of work that has to be done to get to a place of total mental health. And it is an ongoing battle.

Evan admitted that he had made a comment in the past that “was completely wrong and ignorant.” He shared that he had told someone “if you are serving God and you are Holy Ghost
filled, you shouldn’t need to go see a psychiatrist or a psychologist.” He reported that he now disagreed with that belief but did not know any better as a twenty-something. He remarked, I believe somebody can have personality issues, emotional things that need to be dealt with—of course beyond just praying at the altar and what we call “praying through”. They need some time with somebody…And then again…if it is a biological matter, someone can be ill in the mind just like they can be ill…in the heart. If they have heart disease, we would never tell someone, ‘Well, don’t go see a doctor, just get prayed for and get healed.’ By all means, go see a doctor and have faith as well for healing. But yes, go to a doctor. But when it comes to the mind, we think that is just a spiritual thing. It is a strong hold or a devil, it is your wrong way of thinking, and you need to be delivered of that.

Well, maybe so, but can’t someone still be ill in the mind, and be sick in their mind like some of us can be sick in other parts of the body and need some medication?… Or if not medication… meeting once a week and talking for a while. So, I vehemently disagree with my own words from twenty plus years ago.

He went on to say that he believed in secular knowledge despite the fact that some of his minister friends may disagree with him. He discussed how he could lay hands on someone and pray in tongues with that individual and that person may get a great feeling. However, he pointed out that they would still need to learn things about the mind, not just things about the Bible and Spirit. He said that these needed to be integrated.

Claire also acknowledged that some Apostolic Pentecostals were taught that if they had faith they should not need a counselor or medication. She stated, Not all Apostolics are being taught that way…especially today. I think we know a little bit more. But some people were taught that God will heal…if they have that faith …all is
good and well. But some people have been taught… and they are even afraid to talk to anyone or go to any doctor because it is like they do not have faith…they do not want to be perceived as not having faith.

She reiterated that clergy and parishioners needed to understand that there are spiritual issues, but that a person is mind, body, and soul. As such, in order to be whole, he/she may need more help than just the spiritual.

Fred acknowledged that as a pastor he wanted people to try God first on everything because he believed that God could heal anything, including mental health disorders from a chemical imbalance or an emotional wound. At the same time, he believed that depending on the root cause of a problem, a person might need counseling or medication. He believed that healing could occur instantly or gradually. He shared,

I’m a witness that sometimes God does things overnight and sometimes it takes time. I don’t believe there is anything--whether it is a spiritual attack on a person--whether it is a pain in their past--whether it is some sort of imbalance in their system--I believe God can heal any of it. I don’t understand; I don’t have the answers as to why some people get healed and other people don’t. But again, I feel like that God wants us to use wisdom and I feel like that there’s times that people treat God as some sort of a magician or magic trick and we don’t do the things that we need to do ourselves. I mean, sometimes somebody might be 350 pounds and just want prayer all the time while they wonder why their sugar is high. Well yes, let’s get prayer; but let’s do the things that we can do to get our eating habits right, our exercising habits right, and try to be more healthy. I think it is the same with mental health. Yes, we pray and yes we trust God, but at the same time, man, let’s use every tool at our disposal to get my mental health right, just as I would my
physical health…I think people would think you are crazy, to know your sugar is high …and you just drink soda and pray that everything is going to be ok. No, use common sense. I think it is the same thing with mental health. Yes, we trust God, we believe God, but man, if there is well educated and smart people that can help us too, let’s do everything we can do. We do everything in our power and we trust God to do everything in His power…Sometimes, once they get with a good counselor and get on some helpful medicine, then God can heal them from there.

Thus, for Fred, as with the others, God does His part and sometimes that means that He heals completely. However, more often, God does a spiritual work, but individuals must also do their part and attend to the other aspects of life often with the help of others.

Bob’s thoughts were in line with others as well. He discussed the importance of balancing the spiritual with the psychological. He said,

…there is a sensibility and a balance with it. And it is not too far to the right or too far to the left…To me, life is about moderation in everything. You don’t starve yourself. You don’t overfeed yourself.

For Bob, people need to embrace the spiritual care and mental health care in a balanced way.

Finally, George exemplified this principle by giving an example of a member who had a mental health disorder and was prescribed medication. The member wanted to stop the medication. However, George instructed him to walk in faith, yet continue on the medication and stay connected with his mental health professionals. He equated the mental health disorder that needed to be addressed with medication to having diabetes and needing insulin.

George explained this principle later as incorporating good conscience with faith. He shared,
I have faith that miracles happen. I have seen miracles happen. And what I know about miracles is that it is even best to have it documented by the medical professionals. So, I am all for working together with those who have prescribed things or observed things and have them witness a miracle that has happened…I think that is great care and it begins with the same spiritual preparation that should begin every task that we approach as ministers. There is a verse in I Timothy 1:19. It talks about faith without conscience; and some left faith without good conscience and they had shipwrecked. The way that I interpret that is I operate in faith; but I stay connected and present with reality. And if I don’t exercise my faith in my present reality, I will end up in a shipwreck. And so, that is what I use as a guideline in my approach. We operate in faith, but we stay connected to what the reality is and then function and act in accordance with that.

**God is involved in healing.** In addressing the balanced approach to treating the whole person, the clergy made it clear that they believed that God is involved in the healing process. Fred shared that even if God does not heal someone right away, it does not mean that He is not going to do it. He reported that he encourages parishioners to “hold to God in all that.” He went on to say,

We believe that He is active in our lives and He is ultimately in control…Like I said, I can’t explain why people get healed and some people don’t. There are a lot of things I don’t understand. But, I do believe in faith that God is in control and that there is no problem, no situation, there is nothing too hard for God…I do believe that God’s presence in our life will absolutely make things better. Sometimes God changes the situation and sometimes God changes us. And sometimes God will take us around the fire and sometimes He just gives us the strength to walk through the fire. But I do believe
God is with us. And the Bible says it rains on the just and the unjust. So the fact of the matter is that Holy Ghost filled people go through things just like everybody else but the difference for us is that we have God to walk with us through…God is there to walk with us. I am definitely big on that…Miracles are not magic tricks…God is not a short cut. God is not…meant to do what we can do. We have to do what we can and have faith to trust God to do what we can’t. I don’t think God is our crutch or our short cut. He is not a magician…Even in those situations where God does not heal us; He can still bring so much comfort and peace and give us peace to walk through a tough situation.

Thus, individuals do their part; they do not view God as a “magician”, but they allow God to do what they cannot.

In like manner, George believed that God would give those individuals with mental health disorders “the power and strength to bear that cross and even turn that into something they can help others with…” He talked about how “God cares for them and wants to help them.” Bob also talked about how God helps people overcome things and works “for the betterment of people”. Claire also stressed that there needs to be an allowance for inner healing by God and “God can heal anytime in this process.” Evan also shared that he values secular knowledge, but that God’s spirit must also be taken into account. He said, “We don’t want to have all the letter and no spirit.” He discussed integrating the mental health care with the idea that “I can do all things through Christ that strengthen me.” Alan concurred of the importance of not taking God out of the process of healing. He remarked,

I do understand that we do have some power over our emotions over our thought processes and things like that, but…all the power is not in us; all the power is in God and we have to understand that it is only God who can really transform us and change us. It is
not in us ourselves. The only thing that can bring us to that place of healing is the spirit of God in us.

Dan also discussed the importance of understanding that God loves and cares for individuals and wants to help them through their difficulties.

**Preference for Christian mental health professionals.** Clergy preferred mental health professionals who were from a Christian background. They did not have to practice Christian counseling. Some of the clergy required this as a necessary criterion for a counselor working with their parishioners; others simply wanted someone who would not go against their Christian worldview and was not anti-God. This is discussed in more detail in the subsequent section addressing the characteristics that the clergy saw as important in mental health counselors to whom they referred their parishioners and in the section outlining the counselor’s actions that would turn off the Apostolic Pentecostal clergy and their parishioners.

**Clergy Roles in Treatment**

**Spiritual care.** Clergy viewed their roles as supporting the individual through spiritual pastoral care and held a personal responsibility in assisting their members. To them, clergy are there to lead their parishioners in spiritual matters. Claire referred to the clergy member as a spiritual teacher, a type of anchor, and the “flesh of it” or “Jesus with some skin on”. Evan put it this way, “I am a pastor. I can help you with your spirit”. Bob described it in similar terms, as helping “on the spiritual realm”. Alan defined pastoral care as, “dealing with spiritual issues and dealing with the eternal soul, dealing with their relationship with God” and those issues that may affect their relationship with God, church, and their church family. Dan agreed that it would encompass things related to their relationships with God and “relating to the spiritual nature, becoming in harmony with God, relationship with Him, things that would divide the
relationship and separate them with God.” Dan also described it as working with the member on developing the fruits of the spirit in their lives, as well as helping them with issues involving sin. Fred explained the role of pastor as largely encouraging members’ beliefs in God and a Biblical model of living. George outlined his responsibility as pastor:

…to lead them and guide their spiritual development and growth…for everybody…whether they have a defined mental health issue in their life or if they don’t have any mental health issues that are defined or attached to them. Everyone has challenges, and I try to help them develop spiritually.

Interventions. As part of spiritual care, the clergy reported using a variety of interventions within their roles. These were used either with parishioners they thought they could help with various issues or in addition to services some members were receiving from mental health professionals. These included supportive techniques as well as specific faith based techniques.

Supportive techniques. Alan reported that he uses listening, talking, various counseling related books (mostly Christian, some secular), homework, and enlisting the help of his wife. Bob identified using these interventions as well (listening, talking, working with his wife especially on problems with couples). However, where Alan cautioned the use of secular books because of their humanistic themes, Bob embraced secular books and pointed out,

I don’t want to be narrow-minded. Some people are narrow-minded. I don’t want to think just because someone calls themselves a Christian or is a Christian has all the answers. I know better than that. Some of the best material I have got is from books that were written by non Christians…I have used it all. I am telling you what. When you
really want to help the person, you are going to do your best to do whatever you can to help them.

Bob said that he loves to use logic and uses interventions that seek to address communication issues, thinking problems, and self-esteem issues.

Claire, the only clergy member who is currently an evangelist, was clear that she does not counsel with parishioners. She reported that she encourages, listens, shares her experiences, and offers support. Since she ministers mostly to women, she discussed the importance of encouraging them to see their physician to address hormonal issues causing mental health issues.

Dan also reported that he uses the basic skills listed above, including listening to members, and focuses primarily on premarital and marriage counseling, teaching communication skills. Like Claire, he reiterated the importance of encouraging members to see a physician or a mental health professional.

Evan said that he utilizes various avenues of support and said that if a parishioner is going through something that he can help with as a pastor, during that period he would be there more than what would be normally expected. He stated that he would tell a parishioner that I will “go to eat with you, go drink some coffee, have you over the house for dinner, be there as a support as you regroup.”

Fred also reported being supportive and using listening, advice, and talking with an individual. Fred also shared that he connects members with others on the pastoral staff to receive additional support from them.

George also connects his member with other ministers on staff, uses listening, various workbooks, and talking through things. George also talked about going to various places with
parishioners that were sources of problems and/or anxiety and helping the members there, as well as being available when members experience triggers to their mental health issues.

*Faith-based techniques.* As expected, all of the clergy used faith-based interventions with their members, were in the context of spiritual care. Alan’s faith-based techniques included using Scriptures and prayer. He asserted that he tries to “base all of my help on Scripture” and “help them direct their prayer for more guidance for what they are struggling with, what they are dealing with.” Bob also discussed the importance of incorporating faith-based interventions of prayer and the Bible into his care. He said, “I do incorporate Scriptures. I believe that the Bible is the Word of God. I believe that the Bible is powerful. It spoke the worlds into existence…I do use prayer…” Claire also shared that she uses prayer and the Word of God when ministering to others. Likewise, Dan and Fred both discussed using prayer and the Scriptures when counseling with members. Evan reported that he does not do much counseling with members but does utilize prayer and Scriptures as well when ministering. George, like the others, relies heavily on prayer and Scriptures as faith-based techniques.

**Evaluate the problem.** One of the first things that the clergy addressed was the need to evaluate the problem that the parishioner presents to them and determine what is going on. Bob described this process as sitting down with the member for him to listen to “see what their issues may be.” Alan said that he also asks questions, listens to the members, and tries to “get beneath the symptoms to try and find the root of what is going on…” Claire also talked about the need to “see what is going on in their life” and Evan used the term “getting to the bottom of things.” Fred used the same terminology as Alan and said that it was important to determine the severity of a problem and that it depended “on what the root cause is”. Dan also discussed the need to talk to members and counsel with them “to find out where they are.”
Refer to mental health counselor. The clergy reported that once they determine a problem is a mental health issue, as mentioned previously, they would refer their parishioners to mental health professionals. They would provide the pastoral care to address the spiritual life of the individual, but the mental health professionals would provide the mental health care. This theme was addressed in detail in the earlier part of the data narration as part of one of the primary themes regarding beliefs regarding treatment. They preferred to refer to counselors who had a Christian background. Specific characteristics of the counselors preferred in referral sources are addressed in the subsequent section of referrals to mental health counselors.

Led by Holy Spirit. For clergy, an important role involved listening to God and being led by His Spirit in order to be lead their parishioners in the right direction. Dan shared, “…I think first of all, since we believe in being Spirit led, we need to be Spirit led in helping people as well…one of the first things I do is pray and ask the Lord to give me direction in that…the Spirit begins to guide me.” Alan described it as the Holy Ghost leading and guiding him in his role to help discern the root cause of a problem. George shared the role of the clergy being led by the Spirit,

As a pastor, I need to be praying so that God can direct me on what I am to do for each person…I can’t say there is a recipe that always results in the same actions or reactions on my part. As a pastor, I believe that I have to be lead by God and given the direction that I feel from Him.

Role of Holy Ghost (Holy Spirit) in Treatment

The presence of God as active helper. The Holy Ghost, also known as the Holy Spirit, was described as the presence of God or the Spirit of God in the lives of people. The clergy described the Holy Ghost as playing a very real, vital role in the lives of believers and shared
how the Holy Ghost helps both those who suffer with mental health issues and those who are part of the healing process. The Holy Ghost was seen as an active part in Apostolic Pentecostal Christians’ lives and in healing the whole person. The clergy shared that the Holy Ghost is instrumental in transforming lives and is continually working with and in the believer. According to clergy, the Holy Ghost provides peace, gives comfort, offers spiritual guidance, leads and gives direction, encourages, speaks, strengthens, provides insight, gives power, heals, intercedes, helps with thinking and perception, discerns, gives wisdom, and helps with problems. The Holy Ghost’s role is to work with clergy, mental health professionals, and parishioners to bring the members to complete spiritual, emotional, mental, and physical health.

Fred described the role of the Holy Ghost in this way,

We believe that the Holy Ghost is God’s manifest presence in the world today. And we believe that He is active in our lives. And He is ultimately in control…The Holy Ghost—even in those situations where God does not heal us--He can still bring so much comfort…and give us peace to walk through a tough situation...The role of the Holy Ghost is that Christians, or non Christians, go through things; but, it is just so powerful to know that God is walking with you…And it is in some of those tragedies, my goodness, even though God did not remove those tragedies in our lives, He gave us strength to walk through it. That is really helpful.

Fred discussed these roles of the Holy Ghost while discussing the mystery of why God heals some, yet chooses to allow others to go through situations. He went on to reiterate that he did not think God intended the Holy Ghost to do everything for believers or fix all of their problems. However, the presence of the Holy Ghost is real, brings comfort and power to believers, and helps them through everything life brings.
Claire agreed and said that the Holy Ghost could heal, bring peace and comfort, and encourage individuals. She also shared that the Holy Ghost could speak to believers and provide insight into problems, as well as lead and provide direction. She remarked, “The Holy Ghost can…the Spirit speaks through us--and somehow in God’s greatness--we find direction or understanding that maybe we did not have. It is very active.”

Evan stated that the Holy Ghost helps individual as they are seeking wisdom from those that are helping. He stated that it is “the giver of wisdom, the infinite Spirit of God” that leads and guides believers to truth. Like Claire, he discussed how the Holy Ghost can help bring understanding and “bring thing to light”. That is, the Holy Ghost helps believers process thoughts and perceptions against truth/reality.

Alan echoed what Evan and Claire said in that the Holy Ghost leads and guides parishioners to truth and is there as a source of help. Just as Claire pointed out that the Holy Ghost is active, Alan also stressed that the Holy Ghost is constantly working. He also asserted that the Holy Ghost is key in transforming the mind and is necessary for complete health. He commented,

When the Holy Spirit comes, it creates a transformation within the individual and the Holy Spirit is constantly working. The Bible says to conform into the image of God and of course, none of us are perfect yet. But, with the work of the Holy Spirit inside of us, Romans says ‘that we are transformed by the renewing of our mind’. Part of the work of the Holy Spirit is the transformation of our thought processes and the way that we think and the way we look at the world. It really changes the way that we go about life. And so, the Holy Spirit is instrumental in changing that thought process, changing that worldview (for lack of a better term)…So it is absolutely necessary if you want to get a total healing
and a total spiritual, mental, physical help… The Spirit of the Holy Ghost is absolutely vital to that whole process.

Dan discussed the role of the Holy Ghost also as a guide to lead the clergy and the mental health professionals in helping people with mental health issues. He also discussed how the Holy Ghost could speak to clergy during prayer, while they are seeking direction on how to help individuals. In addition, like Alan, he saw the Holy Ghost as a necessary part of the healing process and said that the “Spirit could work together [with clergy and mental health] making them [parishioners] completely whole.”

George concurred that the Holy Ghost’s role was “to lead the clergy, to guide them, give them wisdom, direct them.” He said that he would love to have a resource of mental health counselors that would practice their professions with the same reliance on the Holy Ghost. He also shared that the Holy Ghost could help those with mental health diagnoses. He pointed out that God cared for them and wanted to help them. He acknowledged, as was mentioned previously, that God could heal individuals, however, he also said that the Holy Ghost “will give strength through that [mental health diagnosis] and they can still live a Christian life as a real positive example.”

Bob also saw the Holy Ghost’s role as to guide, lead, direct, and help clergy, mental health professionals, and parishioners. He talked about the Holy Ghost giving believers the power to overcome difficulties and struggles and to help make right decisions about life. When he talked about the role of the Holy Ghost in speaking to believers and leading and directing, he made it clear that it was not extremely mystical. He referred to people that made things extremely mystical as “big eye people” and discussed how they come with “big eyes” and say, “I have a word from God.” He said that they could go “off the deep end of things” and
cautioned that receiving direction from the Holy Spirit is often an individual thing and has a “sensibility and a balance.” This is where he discussed the importance of moderation and the balance of the spiritual and logical.

Mental Health Counselor Roles in Treatment

Mental/emotional care. The clergy saw mental health professionals as those who are educated and trained to deal with the psychological, mental, and emotional needs of an individual. This was clear-cut across all of the interviews. They made a clear distinction between the mental health professionals taking care of mental health and the clergy taking care of the spiritual health and the belief that the two were interconnected. Claire differentiated between the clergy taking care of the spiritual and the mental health professional taking:

care of the body, the body mechanism, whether it is with the brain, sometimes there is just something that is misfiring …rather it is a medicine or rather it is counseling on how to maybe respond differently to stress. I think that is what they touch on.

Alan identified spiritual care as “relationship with people and relationship with pastor” and mental health care as “more the psychological, emotional issues” and asserted that “sometimes those two kind of cross each other.”

Bob agreed that while the clergy took care of the “spiritual realm” the “Christian counselor can help on the psychological. I believe there are two sides. There is the spiritual side and I believe there is the physical side. I believe that both sides have their proper role.” Evan also acknowledged that while the clergy worked with the spirit, the counselors “have a great knowledge of the mind…and “can help you with your mind.”

Fred remarked,
I truly know there are professional counselors who are wonderful. They can talk to people and help them help walk people through past hurts and feelings and they are just so gifted and have helped so many people…And I definitely think getting these people who are well trained in counseling can be very helpful.

Dan also acknowledged that mental health professionals have experience and education in mental health, in matters of the mind.

Although the clergy did not expect nor want the counselors to provide spiritual care, they thought that it was important for them to acknowledge the role that the spiritual plays in the person. This tied into their overall view that treatment of mental health disorders involved the care of the whole individual.

**Works together with clergy.** The clergy also saw the mental health counselors as part of the team in treating these issues in members. When a parishioner that Dan referred to a mental health counselor felt abandoned, he used an illustration to demonstrate his belief in the team concept. He shared,

…this person understood sports. I used sports as an example and shared that you have an offensive coordinator and a defensive coordinator. You have a strength coach. Everybody does something to help you in an area but they are all on the same team. And, I am going to do my very best to help you as I can; but I am going to bring somebody else on the team here. And, they are going to help me with these other things. And together we can get you whole, and they accepted that with more understanding, “I see what you are talking about.”

Claire also stressed the importance of clergy and mental health counselors working together. George shared that he would like for the mental health counselors to be in “partnership” with
the clergy and would love if there were those that relied on the direction of the Holy Ghost as he did. He acknowledged that he was not aware of this being an option at this time. Alan described the mental health counselors working hand-in-hand with the clergy as well. Evan and Fred also discussed the idea of mental health professionals working together with clergy.

**Referrals to Mental Health Counselors**

As previously mentioned, all of the clergy members said that they would and have referred parishioners to mental health counselors. The clergy were cohesive in their preferred characteristics of mental health professionals. The one area where there was some variation was whether they would refer to a mental health counselor who did not have a Christian background. They were also in agreement about the problems that they would send to a counselor, as well as those problems that they would not send.

**Preferred characteristics of mental health professionals.** Clergy preferred mental health professionals who were from a Christian background. They did not have to practice Christian counseling. Yet, the clergy reported being more comfortable when the counselor came from a Christian point of view. Some of the clergy required this; others simply wanted someone who was not anti-God. In addition, clergy wanted those that were educated and had experience treating the issue that they were referring their member for, as well as success in working collaboratively with clergy and churches.

George said that his sole criterion was that they were Christian. He reported that they did not have to practice Christian counseling, but he wanted them to come from a Christian background. He wanted them to be “willing to allow the God factor in their approach to care for their patients.” He asserted that he would love to work with a counselor who also relied on
the leading of the Holy Ghost in their care and if he knew of a Pentecostal counselor, he or she
would get all of his referrals.

Dan said that the three characteristics that were important to him were the counselor has
the proper education regarding mental illness, he/she has a “God background,” and he/she has
some experience treating the issue that he is referring to him/her. He shared,

…I like for them to have a God background…at least believe in God. And the reason for
that is if I am helping them in some areas of life and I am talking about God and the other
person I am referring to them on the mental illness side--which is a very serious thing
with the mind--I don’t want them putting anything into their mind adverse about God.
(Not saying they would.) But I want to make sure they are letting these people know that
‘God loves you, God cares about you.’ I want them to be okay to talk about God, and
some professionals are not okay to talk about God. Even if that person says ‘I want
someone to pray with me’, I want that person to feel comfortable enough to say a prayer
with them. I would like to have someone so that we work in harmony. If I am believing in
God and the person that I refer them to does not believe in God, somewhere down the
road, that is going to come up. And I feel that puts that person that is being counseled by
both…I think that would be a conflict of interest.

Alan also wanted a counselor who had a Christian background. He shared that he would
like to refer to a counselor who had a good working relationship with other churches and clergy.
He reported that he has contacted pastors in his local area to ask them who they have had
success working with. Alan said that because he felt responsible for his parishioners, he wanted
to work with the counselor. He thought it was important to work hand-in-hand. He said,
I don’t want to refer to someone where basically I am going to be shut out and that counselor is going to say disregard everything your pastor says. You know. That kind of puts me in a tough spot because I want to still be working with that person because I feel responsible for my parishioners.

Claire agreed with the others on wanting to refer to a counselor with a Christian background. Claire, like Dan and Alan, also wanted a counselor who has a good reputation and collaborative relationship with churches and clergy. In addition, Claire highlighted the importance of the counselor being balanced and acknowledging the whole person, a central theme of treatment in the interviews. She asserted, “I like them to look at the whole. They don’t just look at it from a medical point of view. They look at it from a spiritual point of view also.” She wanted the counselor to have practical skills to share with the individual, while also being comfortable in addressing the spiritual side.

Evan also discussed the preference for a counselor who was a Christian. As George mentioned, Evan said the counselor did not have to practice Christian counseling. In addition, the counselor did not have to agree theologically with him because the parishioner was not seeing the counselor for spiritual care.

Fred shared what would make him comfortable is for the counselor to not be “anti-God.” The counselor did not have to be Christian, just not be against God. He did share that if he had a choice between two equally skilled counselors and one was a Christian and was not, he would choose the Christian counselor. He put it this way,

They don’t have to be Christian…I am not expecting them to be like I am as a pastor. But me, I just don’t want them to be anti-God…For me to be comfortable with them, they don’t have to lead with God. I don’t expect them to be a pastor or even a devout
Christian, but not anti-God would be one thing. If they could help people and they are making a difference, I am for it. I am good with it. Obviously if…there are people are at the same level of skill and one is a Christian and one is not, I would definitely love to refer to the Christian counselor, but as long as the counselor is not anti-God…I don’t have a problem with it at all.

Bob shared Fred’s view that the counselor would not have to be Christian in order for him to feel comfortable with a referral. He said that he would definitely not send anyone to an atheist because it affected the way the counselor thought and thus the way he/she would conduct counseling. He stated that as long as he/she had good logic and had good basic morals, he would feel comfortable referring to him/her. Bob said that these counselors would not take care of the spiritual things, so as long as they were willing to allow the members to believe in God, he would feel comfortable. He explained it this way,

Somebody that would believe in God, that God exists and…that He basically made the world. They may not say, ‘Well, I’m a Christian; I go to church…’ Once again, there’s good people out there. They have good basic morals…good sense of balance of life.

**Problems that clergy would send to mental health counselors.** The clergy reported that they would send any problems that they felt were mental health problems to mental health counselors. They were comfortable sending any mental health issues that they were not equipped or trained to handle. A variety of issues that were mentioned by name included abuse, anger, anxiety, homicidal and suicidal ideation, marriage and family issues, depression, divorce, serious psychotic symptoms including hearing voices and problems in communication, and severe mental illnesses such as schizophrenia and bipolar disorder.

George summarized what many of the clergy members discussed. He said,
Any of the problems that I already mentioned would…something that continued as a problem and I met with the individual and helped them the best that I can and it seems that it is really not sufficient to address the symptoms and the root causes that they are experiencing.

Problems that clergy would not send to mental health counselors. All of the clergy reported that they would not send problems that were viewed as spiritual in nature to mental health counselors. They felt that these fell under their responsibilities of pastoral care. Alan explained,

…things where people come to me and say, “I just don’t feel God anymore”…if there is definitely a spiritual issue--more about their walk with God--I am not going to refer them to counseling. That is something for the pastor. That falls under my skill. An outside counselor is not going to be able to help them. So, things that are definitely a spiritual issue...regarding their walk with God and their relationship with God--even their relationship with the church or their relationships with people in the church. Those are things that fall under my spiritual care.

Dan specified that he would not send premarital counseling issues to a mental health counselor only because he liked to counsel with members he planned on marrying. He reported that it gave him a chance to connect with the members and get to know them.

Important Things for Counselors to Know About Apostolic Pentecostal Christians

The strongest theme that was evident in response to this question was that Apostolic Pentecostal Christians operate within the context of a faith-based spiritual worldview. Clergy reported that Apostolic Pentecostals greatly value the Spirit of God and the Word of God in their lives. God is at the center of all aspects. They highly regard their faith. Clergy asserted
this worldview is a strength that the counselors need to embrace and work with in order to have a successful counseling relationship. Another strong theme that emerged was the impact of past Apostolic Pentecostal teachings. Past teachings viewed secular knowledge and modes of helping as unnecessary for those that had God’s Spirit. These past teachings affect how some outside of the faith tradition perceive Apostolic Pentecostals, as well as how some Apostolic Pentecostals perceive getting outside help. Some of the clergy addressed this by discussing the importance of counselors knowing the clergy do not endorse these past teachings and embrace education and outside help. Other clergy addressed it by discussing the need for counselors to know that some parishioners may still hold these beliefs and counselors may need to encourage members that it is okay to need additional help.

**Faith-based spiritual worldview.** Clergy reported that Apostolic Christians operate within a strong faith-based spiritual worldview and counselors need to embrace that in the counseling relationship. Fred described this by saying,

…God is very much in the center…maybe even more so than in other religions. Most people who are Apostolic Pentecostal are very committed to their faith and they have made some commitments to God…We do put our trust in God. So, God is probably going to come up a lot in counseling, and so I guess they would just need to be prepared to deal with that…As long as someone is not anti-God, I don’t think they would have any trouble with counseling one of our people…I think we are just average common good people like…the majority of Americans are. So, I don’t think there is any standout thing to look out for. But it is just to know that if you are anti-God that ‘marriage’ is probably not going to work with an Apostolic person; you are probably not going to be in a long term…because I just feel that most…A stable Apostolic really puts a lot faith and stock
and trust in God. You will have to embrace that in your counseling, rather than try and avoid it.

Fred acknowledged that some “casual Apostolics” could be swayed against God. But for the most part, Apostolic Pentecostals are very strong in their faith in God and counselors need to be aware of that.

Alan echoed the sentiment that believers held a strong belief in God,

We are heavily reliant on Scripture and the Spirit of God in all of our care and all of our parishioners. And when it comes down to it, that is going to be our final authority and the Word of God is our final authority. And that flies in the face of a lot of science…The Word of God is the final authority on everything. And that is where I draw the line and where I feel that all Apostolic Pentecostals should draw the line…is the Word of God.

Bob also shared that counselors needed to know that the Spirit of God is very important in Apostolic Pentecostals’ lives and they find satisfaction in their relationship with God.

Claire agreed that Apostolic Pentecostals believe strongly in the Spirit of God and counselors cannot change that. She remarked,

…They believe in the Holy Spirit…They do believe that the Holy Spirit has a work in their life; it works in their life. And while in the natural, the medical field, would look at the scientific part as a whole…There is a spiritual part for them, and you don’t necessarily separate them. It is part of the process…It is their faith, part of their faith--whether the mental health professional believes in it or not--an Apostolic does and you are really not going to change that because they have experienced it and that is part of their faith.

Dan supported this idea and said,
They have a strong belief in prayer. They believe in following the Spirit. They have respect for authority in God. It is something that is very paramount in those people’s lives. If the counselor tries to undermine any of those they may not be as successful as they could be if they just recognize those pillars in their life are very strong. George also discussed the importance of counselors knowing of Apostolic Pentecostals’ strong faith. He said that it would “be important that we believe anything is possible…the real extent of our faith…A significant portion will err on the side of faith rather than on the side of caution.”

The clergy reported that Apostolic Pentecostals’ belief in God and the spiritual is an integral part of their lives. They asserted it is as real as any other aspect of their lives and counselors need to work within this context in order to best help them. This importance of the spiritual was shared throughout the interviews.

**Impact of past teachings on perceptions.** Throughout the interviews, the clergy discussed the importance of looking at the whole person and endorsed the value of secular knowledge and treatment with counselors and medication, while simultaneously stressing the inclusion of spirituality and faith based treatments as supportive care. They stressed the co-occurring belief in God as a healer, as well as the belief that clergy and mental health professionals provide healing beyond what God and His Spirit can do. However, they acknowledged that some Apostolic Pentecostals might have difficulty with needing additional help beyond the Holy Spirit. This theme was embedded throughout the discussions and again addressed when sharing what would be important for counselors to know about Apostolic Pentecostals.
In the past, Apostolic Pentecostal teachings viewed secular knowledge and modes of helping as unnecessary for those that had God’s Spirit and did not embrace the incorporation of spiritual care and mental health care. These teachings still have an impact on both how Apostolic Pentecostals are perceived by some outside of the faith tradition, as well as how some Apostolic Pentecostals perceive getting outside help. Some of the clergy addressed this theme by discussing the importance of counselors knowing the clergy did not endorse these teachings and embraced education and outside help. Other clergy members addressed it by pointing out that counselors need to be aware that the impact of those teachings may still linger in Apostolic Pentecostals and counselors may need to encourage members that it is okay to need additional help.

Alan, after discussing the importance of Scripture and the Spirit of God in Apostolic Pentecostals’ lives, discussed the need for counselors to be aware that clergy no longer embrace the past teachings. Not only do clergy value knowledge and resources in addition to the Spirit, they also encourage their members to seek outside help. He shared that often when he meets with someone for the first time, he must dispel some preconceived notions about Apostolic Pentecostals. He said that he often had to dispel the myth that Pentecostals are “crazy” and “snake handlers and this and that and the other.” He said when he meets with someone for the first time, he informs them that he is “not some uneducated backwoods guy who has no clue what he is talking about.” He reported that he spends his time, money, and energy becoming educated and being “up on the modern way of doing things.”

He went further and remarked,

I am not some backwoods person that depends on the Spirit and never does anything to increase my knowledge. ‘I’m never going to do anything to better myself. I am just
going to depend on God’. Well, yeah, I depend on God; but I also realize that God gives us a brain and God gives us abilities…That is why I spend so much time being educated. And that is a stigma, as a movement, that we are having to face against. And we are having to get over that preconceived notion to the world including the medical field and the mental health field and a lot of different fields.

Alan asserted that Apostolic Pentecostals must work through the preconceived notion of generations gone by that they are against education and are uneducated people. He reported that this assumption was particularly true in the past and although it is not as prevalent today, it is a stigma that Apostolic Pentecostals still fight.

He said that it is important for mental health counselors to know that Pentecostals acknowledge the roles of clergy and the Spirit. At the same time, they acknowledge the mental health counselors roles and their knowledge and want to collaborate with them and work hand-in-hand to address these mental health issues. He stated,

I want to provide the best care I can for the saints who have entrusted their souls to me. I want to be able to provide the best care I can so that is why I am not hesitant to go outside and get help.

Bob’s comments echoed the feeling of fighting the false ideas that others have about Apostolic Pentecostals not being educated, noting that he, as a pastor, had faced this belief from individuals outside of the Pentecostal tradition, specifically mental health professionals. He thought it was important for mental health counselors to be aware that Pentecostals do value logic and incorporate secular knowledge into treatment. He thought it was also important for counselors to acknowledge and respect the role of the clergy and work hand-in-hand with them on helping individuals.
Dan and Claire discussed the other side of the coin and said that because of past teachings and the belief in healing and faith, it was important for counselors to know that some Apostolic Pentecostals may have some hesitation in seeking outside help and need to be encouraged that individuals can have faith and still need additional help. Dan said counselors, should know that they have a strong belief in God and that God can do anything…nothing is impossible with God. But they would also need to be able to help those people check into reality that God does not heal everybody. He can--and many times He does-- but when He doesn’t, it is okay to get other help that He provides for us. Claire also pointed that counselors should know …that some of the teaching that they have received is if you have faith, you shouldn’t have to need a counselor or medication. I think that is part of it. And not all Apostolics are being taught that way--especially today. I think we know a little bit more. But some people were taught that God will heal and if they have that faith all is good and well. But some people have been taught--and they are even afraid to talk to anyone or go to any doctor because it is like they do not have faith. They do not want to be perceived as not having faith. I think that is one issue.

Thus, according to the clergy, it is important to know that Apostolic Pentecostal clergy are aware of the beliefs that were taught in the past and acknowledge that some parishioners still hold to that belief that if individuals are spiritually healthy, they should also be emotionally, mentally, and physically healthy and should not need care from mental health professionals. However, as they shared, the clergy believe strongly in the incorporation of spiritual care and mental health care. They advocate for those outside of the Pentecostal faith tradition to become
aware of what the clergy actually believe, while addressing these lingering beliefs with some Apostolic Pentecostals.

**Collaboration with Mental Health Professionals**

The clergy all said that they would collaborate with mental health professionals on meeting the needs of their parishioners and stressed the importance of doing so. This tied into their overall beliefs that mental health disorders should be treated by counseling and medication with concurrent spiritual care. Their descriptions of collaboration were congruent with one another and involved working together in a reciprocal manner. The things that the mental health counselor could do that would turn the clergy and their parishioners off were directly related to their preferred characteristics of mental health professionals.

**Clergy views of collaboration.** The clergy believed that collaboration with mental health counselors should involve the two working together within their areas of expertise to meet the needs of the parishioners, communicating, respecting one another, sharing ideas of how to treat the member, and respecting boundaries and confidentiality.

George shared that collaboration would involve working together with the counselor. He reported that with the “proper permission granted” from the parishioner, he would love to have some sessions where the clergy member and the counselor both met with the member. If that were not possible, he would like to have “offline communications” where the person was not involved so they could coordinate care. He also felt that

It would be wise for any pastor to lean on the professional’s knowledge of state and federal regulations so that we not just meeting the legal requirement but meeting the highest ethical requirements for our practice of trying to collaborate.
Bob concurred that collaboration would involve the two working together, sharing responsibility for the individual and sharing ideas on how to help the member. The clergy would focus on the spiritual care and the counselor would focus on the mental health care. Both would operate from a place of mutual trust and respect.

Alan saw collaboration as being very important, even vital. He acknowledged that it was “probably not old school Pentecostal. But it is where we live today.” He reported that details of collaboration would vary from case to case. He said that he has not had to do as much collaboration with counselors recently. He said he did more collaboration when he was pastoring in a larger city and had more resources. He discussed, as Bob did, that he did not want the counselor to take over spiritual care, as a pastor, that was his role. He said he viewed collaboration as a mutual understanding and trust and said,

It is working with the understanding that we are working together. And if necessary I know that I can call that individual and say “Hey, we are dealing with this, and I know that this person is seeing you, can we help each other out here?”

Evan also wanted collaboration with a mental health counselor to be a relationship built on mutual respect and thought it would be wonderful to work with a counselor on meeting members’ needs. He acknowledged working within the boundaries of confidentiality, but wanted to encourage the parishioner to give permission for him to communicate with the counselor. He reported that he would love to have the counselor to simply email him on occasion and let him know how counseling was progressing in order for him to reinforce the things that the counselor was working on with the member, as well as how he, as pastor, could help the client. He distinguished, as Bob and Alan did, that he would continue to provide spiritual/pastoral care concurrent with the mental health care. He reported that he would love to
establish an ongoing relationship with a counselor that he was comfortable with who already knew the basic Pentecostal beliefs and work with that understanding. Evan reported that if a member was seeing a mental health professional, he wanted to coordinate care with the counselor. He would not want to be meeting with the member and not be able to coordinate care.

Claire also addressed collaboration in the context of working together and respecting confidentiality. She reported that she would collaborate with a counselor if requested. She reported that she would like to share input. She saw collaboration as having the counselor help the clergy in general to know how to best help parishioners with mental health issues that come to clergy and what to do to help in the process.

Fred reported that he would be glad to collaborate with a mental health counselor. He reported that when a parishioner is meeting with a counselor, he tries to meet with the member as a source of support, “to reinforce that the church is doing our part to stand with this person.” He shared that he wants to reassure his members because when they know that the pastor supports the work that the counselor is doing, it provides a sense of relief. Fred said that he thought it would be good for the clergy and counselors to work together, he just did not know what kind of system would work best. He shared that in the past seven years, he only sat down one time and met with a counselor who was working with a church member. He reported that “we kind of got our heads together”. He did not know if those types of meetings would be beneficial, but agreed that clergy and mental health counselors working together to help the person was a good idea.

Dan also discussed the importance of working together, being on the same page, and working within the context of confidentiality. He was unique in that he shared that he would
like to have a professional mental health counselor as part of the pastoral staff at his church so that they could work together closely. He said that he would introduce that counselor to the church and would let members know that the counselor was available. He would then go through a referral process and would adhere to strict boundaries protecting the members’ confidentiality. He discussed the team approach and reiterated the separate roles of clergy providing the spiritual care and the counselor providing the mental health care. He stressed the importance of working together, but not having the counselor share details of counseling with him. If the member wanted him to know something specific addressed in counseling sessions, he would ask that the member share that with him directly.

When the researcher asked how Dan would collaborate with a counselor if he could not have one on staff, he replied that he would want to go through an interview process to assess his comfort level with referring members and working with him/her. He said that he would speak to the counselor and let him/her know where he stood as a pastor and

…would ask them questions about what they believe about God. I would go through more of an interview process with them and find out where they are at, what their background was, what they believe. And if I felt comfortable where they were on those questions, I would let them know I was looking at having a relationship between them and the church that I could refer people to them…that I needed to know that we were on the same page on a few things before I could start sending people that way.

He went further and explained that he had made a mistake trusting someone else’s referral when he sent a member to a counselor. He reported that the counselor did not help the member so he now felt the need to interview potential counselors himself and make sure he was comfortable before he sent members to him/her.
Things that would likely turn Apostolic Pentecostal clergy and parishioners “off”.

Clergy shared that negating or not recognizing the spiritual component of the whole person would turn them and their parishioners off. This could be accomplished by (a) directly telling the parishioners that their faith and spirituality were not important, (b) instructing them to disregard their spiritual worldview and belief in God, (c) encouraging them to go against their values and morals, (d) discouraging their faith-based practices, (e) negating the role of the pastor in their lives, and (f) telling them their faith-based practices are the causes of their problem, and being “anti-God”. This could be accomplished indirectly by encouraging a humanistic point of view.

Dan said that negating the spiritual realm, going against their belief in God, and tearing down the spiritual authority of the pastor in their lives would likely turn parishioners off. He said if the counselor would

Tell you, “God couldn’t help you. There is no need to pray about it.” Tear down spiritual authority in their life. Tell them that what they believe in is not real…that they don’t need to trust in that. That is some of the main things. And that they don’t need to believe in Jesus.

He continued, Apostolic Pentecostals would be turned off if the counselor created a conflict in their belief systems and if he/she went against the pastor, anyone in authority in the church because we would hope to be working together. And if they begin to derail what their strength is--if someone starts tearing them down--I don’t think that is healthy for them. They would have to separate in their mind whether to believe the counselor or believe the pastor. That is tough for people.
Dan reiterated the need for a balanced approach so that the clergy and the counselor are working together to meet the needs of the members. He stressed the importance of the individual following the counselor and the clergy. However, if these two conflicted, he acknowledged this would turn the parishioners off.

Claire echoed this and shared that if the counselor went against the Biblical values and morals that would turn members off. Also, counselors should acknowledge the spiritual part and not “put people in a box.” She remarked,

To come from a scientific point of view only, that is when they can make the problems bigger than they are or create more of an issue…The Holy Spirit…has a part in that, in who we are, the spiritual part…who we are. And so, I think we need to be careful about all of it, of putting people in a box. We need to look at the whole person…where they’ve been, where they are.

George’s response was congruent with Claire’s thoughts. He reported that coming from a scientific or biological point of view only and ignoring the spiritual aspect would be a problem. He stated, “…Ignoring or disallowing and disrespecting the God factor or the unusual push toward medication or additional medication would probably turn off most Pentecostal ministers and or parishioners.”

Fred said, “Just being anti-God and counseling people to do things that conflict with Biblical values and some of our core beliefs…discouraging church, discouraging that kind of thing...” would turn Apostolic Pentecostals off. He continued, “Again, I don’t expect them to have to lead with God like I do, but just not be anti-God.” He said for the counselor to take “away the central part of who they are” would be a problem.
Evan agreed that a counselor directly going against beliefs and telling the parishioner that he/she is wrong would cause clergy to stop sending him to see that counselor. In addition, Evan said that the counselor could indirectly go against Biblical teaching by “interjecting false ideas…in humanistic ways.” He acknowledged the counselor might not do this intentionally, but it would still cause some concerns.

Alan also discussed that counselors could turn Apostolic Pentecostals off indirectly or directly. He also stated that the counselor could indirectly turn members off by coming from a humanistic background that “takes God out of everything” and “takes the relationship of God out of the care of the person in need of help.” As the others indicated, Alan said that the counselor would turn the parishioners off if they negated the importance of the spiritual life or say that the problem is the fact that they are going to church and listening to a pastor. In addition, shutting the pastor out of care or saying that the pastor cannot help would likely turn off Pentecostals. Bob also talked about that the counselor not recognizing the spiritual needs of members would turn members off, as well as negating the importance of the pastor in members’ lives.

Summary

Apostolic Pentecostals identified seeing a variety of mental health issues with a range of severity in their parishioners. These included marriage and family issues, issues related to trauma and abuse, as well as mental health disorders including anxiety disorders, mood disorders, personality disorders, substance related disorders, developmental disorders, and schizophrenia. Some clergy members understood the phrase “mental health issues” in the literal sense of the word as dealing with cognition and first identified those issues that fell under that
umbrella. Once they were asked about other emotional issues, they identified additional mental health issues.

The clergy attributed mental health disorders to a variety of causes, including biological components, life circumstances, family environments, and individual differences. Spiritual factors were discussed in terms of past beliefs or rare occurrences, and not as primary causes for mental health issues. All endorsed more than one cause for mental health issues and some shared that because of the complexity of mental health disorders it was hard to determine their causes. They shared that they believed that the causes depended on the issue and the individual.

Several themes regarding the beliefs of treatment emerged. These included (a) mental health issues should be treated by mental health counselors with counseling and medication and the clergy providing concurrent spiritual care, (b) treatment should address the whole person, (c) mental health treatment and spiritual care work together in the healing process, (d) God is involved in healing, and (e) they preferred mental health counselors have a Christian background.

Clergy saw the roles of clergy, the Holy Ghost, and mental health counselors as working together to meet the needs of the whole person, including the spiritual, emotional, mental, and physical. Clergy saw their role was to provide spiritual care using supportive and faith-based interventions. They also discussed their role was to evaluate the problem, be led by God’s Spirit, and refer mental health issues to counselors. The clergy believed the role of the Holy Ghost was as a help both for those who have mental health issues and for those who are part of the healing process. The Holy Ghost is as an active part in Apostolic Pentecostal Christian’s lives and is viewed as instrumental in transforming the believer. According to clergy, the Holy Ghost provides peace, gives comfort, offers spiritual guidance, leads and gives direction,
encourages, speaks, strengthens, provides insight, gives power, heals, intercedes, helps with thinking and perception, discerns, gives wisdom, and helps with problems. The Holy Ghost works together with clergy and mental health counselor to meet needs of parishioners. The role of the mental health counselor was seen as providing emotional/mental health care and working together with clergy. The clergy clearly believed that mental health counselors should acknowledge the importance of the spiritual aspect but do not provide spiritual care offered by clergy.

All of the clergy discussed referring mental health issues to counselors as a key part of treatment. In discussing characteristics that would make them feel comfortable with their referrals, clergy reported that they preferred mental health counselors who were from a Christian background. They did not have to practice Christian counseling. Yet, they reported being more comfortable when the counselor came from a Christian point of view. Some of the clergy required this; others simply wanted someone that was not anti-God. In addition, clergy wanted those that were educated and had experience treating the issue that they were referring their member for, as well as success in working collaboratively with clergy and churches. Clergy shared that they would send any problem they saw as a mental health issue to a counselor. They reported they would not send a problem that was viewed as a spiritual problem to a counselor. Spiritual problems were defined as those relating to the parishioners’ relationship with God, the church, and church members.

The clergy reported that it was important for the counselors to know that Apostolic Pentecostal Christians operate within the context of a faith-based worldview. Also, it was important that counselors know that past Apostolic Pentecostal teachings impact perceptions. The past teachings that viewed secular knowledge and modes of helping as unnecessary for
those that had God’s Spirit still have an impact. The teachings affect both how some outside of
the Pentecostal faith tradition perceive Apostolic Pentecostals, as well as how some Apostolic
Pentecostals perceive getting outside help. Some of the clergy addressed this by discussing the
importance of counselors knowing the clergy did not endorse these teachings and embraced
education and outside help. Other clergy members addressed it by discussing the need for
counselors to know that some parishioners might still hold these beliefs.

The clergy all said that they would collaborate with mental health professionals on
meeting the needs of their parishioners and stressed the importance of doing so. This tied into
their overall beliefs that mental health disorders should be treated by counseling and medication
with concurrent spiritual care. The clergy believed that collaboration should involve clergy and
counselors working together within their areas of expertise to meet the needs of the
parishioners, communicating, respecting one another, sharing ideas of how to treat the member,
and respecting boundaries and confidentiality. Clergy shared that negating or not recognizing
the spiritual component of the whole person would turn them and their parishioners off. This
could be accomplished by directly discouraging their faith-based worldview or indirectly by
encouraging a humanistic point of view.
Chapter Four-Summary, Discussion, and Future Directions

Summary

A core competency of counselors is to embrace client diversity and practice in a culturally appropriate manner. It is important to recognize clients’ unique cultural contexts and the resulting “lens” in which they view the world. This shared “lens” of perception affects the way people understand and live within their world. This includes how people define illness, including mental health disorders and the perceived causes, as well as the accepted modalities of treatments. One important cultural variable that is gaining more attention in the professional literature is that of religion. Religion impacts people’s lives on different levels. For some, it can be a silent or absent thread of influence and for others, it is a very potent influence.

Religion has been defined in various ways and involves complex belief systems that are lived out in practices and rituals in an attempt to find purpose and personal significance. It is a shared ultimate reality. Religion has been viewed as an asset, a liability, or a combination of both. In the context of ecological counseling, religion is understood as an important web of influence and is connected to meaning making in the grand ecosystem of the universe, asking the deep questions related to our purpose here on the earth. It is often a very important part of the meaning making process for individuals. The shared meaning derived from religious experience shape worldviews.

Pentecostals espouse a specific worldview that lends itself to a unique cultural lens of understanding mental health disorders. They believe in a world composed of more than just that which can be seen with the physical eye, a world that is also composed of a spiritual realm that is both influential and integral to their every day lives. Specifically, they believe in the transforming experience of the Holy Spirit. They believe the miraculous and spiritual
experiences that were experienced in the first century church are available and occur today. As such, they believe that divine healing from illness is attainable if God wills it so. These beliefs in the supernatural, as well as ways they are lived out, are important to consider when discussing views regarding mental illness causes and treatments. In addition, some embrace various social norms and mores associated with the Holiness movement as exemplifying Christian living. As such, they highly value the role of the clergy and often turn to them for help with mental health problems. In addition, clergy may hold different beliefs regarding mental health disorders. Thus, studying the beliefs of the Apostolic Pentecostal clergy was beneficial in understanding the growing number of individuals identifying as Pentecostal, as well as ways to collaborate with clergy on meeting their needs.

The literature on the beliefs regarding causes and treatments of mental health disorders indicated that religious culture does play a role in how groups of people view mental illness. Over the years, the American public has embraced more biological and social/circumstantial causes for mental health disorders and less individual/moral causes. However, studies with Pentecostal Christians endorsed the biological and circumstantial, but also highlighted the spiritual (as opposed to individual/moral factors) as cause for mental illness.

Regarding treatment of mental health disorders, the American public has endorsed a variety of treatments, with an increase in willingness to seek professional help. These include sources of help included family and friends, physicians, mental health professionals, clergy, and medication. Christians, including Pentecostal Christians, also acknowledged secular mental health treatment options including medication, mental health professionals, and psychiatrists. Yet, they also advocated for faith-based treatments to be included and preferred treatment by like-minded Christian professionals before secular mental health professionals. It is evident that
Pentecostal Christians’ complex view of mental health disorders entails a dimension often left unconsidered by the general public: the spiritual.

The purpose of this study was to explore the beliefs regarding mental health disorders, as well as the associated practices of Apostolic Pentecostal clergy. It sought to understand their beliefs in the context of their worldview. Despite the plethora of studies on Pentecostals, few have studied their beliefs regarding causes and treatment of mental health disorders, and none have focused specifically on Pentecostal clergy beliefs.

A semi-structured telephone interview was used to ask seven participants a series of questions. The semi-structured interview allowed the researcher the opportunity to ask key questions about the desired subjects, while allowing the participants to tell their story. The semi-structure also permitted the questions to serve as a guide and for additional questions to be generated as a result of the natural progression of the participants’ responses.

The study was a qualitative study and the guiding questions were created based on the literature involving beliefs regarding the causes and treatments of mental health disorders and the Pentecostal worldview, situated in the context of religion, culture, and meaning making. The data was analyzed using an editing style. Three levels of coding were used. In the first level, coding was mostly descriptive. In the second level, categories within the questions were used to group main ideas according to relatedness. Finally, trends were identified using triangulation comparing data across participants.

The results found that Apostolic Pentecostal clergy viewed biological and psychosocial determinants as causes of mental health disorders. They did not endorse spiritual factors as causes for mental health disorders. They endorsed professional counseling and medication with concurrent pastoral care to address the whole person—viewed as physical, emotional/mental,
and spiritual. Treatment was viewed in the context of healing. They believed that God could heal any problem, including mental health disorders, instantly or as a gradual healing process that incorporates the clergy and counselors working together with the help of the Holy Spirit.

The clergy saw their role as providing spiritual care while supporting parishioners as they received concurrent mental health care. Mental health care was viewed as that dealing with the emotional/mental or psychological and provided by professionals. The Holy Ghost was viewed as an active helper to both parishioners suffering from mental health disorders, as well as the clergy and mental health counselors who work with them.

Clergy embraced collaboration with counselors, with a preference for counselors who believed in God, were educated and well trained, had experience, and had a history of a collaborative relationship with clergy and churches. Negating the importance of the spiritual realm, or going against their faith-based practices either directly or indirectly would create problems for them.

Clergy shared it was important for counselors to know that Apostolic Pentecostals operate within a strong faith-based worldview. In addition, clergy embrace education and outside help. However, their parishioners may have difficulty asking for help based on past teaching that taught that if one had God’s Spirit, they would not need outside help.

**Discussion**

The findings of this study highlight the webs of significance found within what Sue and Sue (2003) define as the group level of human identity, that is, how individuals are “like some individuals” (p.11), specifically the group level of religious culture. The results support the assertions by researchers (Brown, 1995; Furnham & Chan, 2004; Furnham & Malik, 1994; Furnham & Henley, 1988; Sue & Sue, 2003; Sussman, 2008) that culture influences how people
think, make decisions, behave, define events, as well as believe what causes mental health disorders and how to treat them. In addition, the responses show how each cultural group may have its own distinct way of interpreting reality and give a different perspective on the nature of people, the origin of disorders, standards for what is judged as normal and abnormal, and therapeutic approaches (Sue & Sue, 2003).

The findings show that the cultural lens in which the Apostolic Pentecostal clergy view their world affects their beliefs and practices related to mental health disorders. They presented a shared view of what causes mental health disorders, how they should be treated, and who they trusted to provide treatment. These reflect the three components Sussman (2008) discussed as the conceptual, personnel, and behavioral components of beliefs and practices related to illness. (The conceptual components include beliefs regarding the cause of an illness, as well as expectations regarding prognosis; personnel components refer to those regarded in the community as trusted healers. And finally, behavioral components constitute the norms when seeking treatment and consulting healers.)

These shared experiences emphasize religion as what others have defined as a “web of significance” provided by culture and constructed by human community. The Apostolic Pentecostal faith tradition forms a sense of personal identity and provides what Shafranske and Malloy called a “‘sacred canopy’ under which spheres of relevancy are created that orient human values and ultimately determine behavior” (1996, p. 2).

Thus the findings of this study are interpreted within the context of the Apostolic Pentecostal worldview. Specifically, as the ecological counseling perspective asserts, they are discussed with the understanding that individuals are not just a part of cultures or environments, but have a dynamic interactional relationship with their environments and derive meaning from
them (Conyne & Cook, 2004). This interactional web of significance and the meaning the Apostolic Pentecostal clergy make out of them is reflected throughout the findings.

**Mental Health Issues**

The clergy in this study reported seeing a variety of mental health issues across many areas with a range of severity. These involved issues related to everyday living, as well as diagnosable mental health disorders. As other studies (Blank, et. al., 2002; Burgess, 1998; Chalfant, et. al., 1990; Franklin & Fong, 2011; Harley, 2006, Koenig, 2005; Koller, 1994; Larson, et. al., 2000; Pickard & Guo, 2008; Trice, 2003; Wang, et. al., 2003) have indicated, the majority of clergy shared that parishioners often turned to them for help with these mental health issues and social problems. Only one clergy member shared that his parishioners did not come to him for help as much as he had expected. He attributed this to the culture of poverty within which he pastors. He reported that due to generational poverty, many of his parishioners accept the “hand they are dealt” and do not want—or believe—that change can happen. Thus, they do not reach out for help.

The interesting part of the clergy responses to mental health issues observed in some members was some of their understandings of the phrase, “mental health”. Starr (1955) had found that Americans had narrow definitions of mental illness and often associated it with psychosis, resulting in negative stereotypes of those with mental health disorders. However, later studies (Gurin et.al., 1960; Kulka et al., 1979) found that Americans were more likely to identify problems in mental health terms. And Pescosolido et al. (2001) found that most Americans were able to correctly identify several mental health disorders. These findings, with some of the clergy not understanding the term “mental health” as including all mental health
disorders, are inconsistent with the general public’s ability to recognize the broad spectrum of mental health issues.

Considering the context of the Apostolic Pentecostal worldview, these findings may simply be attributed to the lack of exposure to the professional mental health world. This could be connected with their past teachings that taught if believers had the Holy Spirit, they did not need additional help. Thus, historically, Apostolic Pentecostals may have dealt with mental health problems “in house” per se and leaned on the Holy Spirit and clergy to treat these issues. The problems that were manageable using the tools at their disposal may not have been labeled as “mental health” issues. They may have simply been identified as normal everyday problems that could be “overcome” by God’s Spirit. As a result, only those severe cases that were noticeably different may have been understood as “mental health”.

Despite the fact that all of the clergy interviewed understood mental health issues in the context of the whole person, the lack of understanding of the term “mental health” in a broader context could just be the result of the lingering effects of their shared history. This is only conjecture; the true nature of the reasons behind some of the clergy’s initial misunderstanding of the term “mental health” would need to be investigated further.

**Beliefs Regarding Causes of Mental Health Disorders**

The finding of multiple determinants of causes was different from those found in previous studies of Pentecostal Christians as well as clergy from various faith traditions. Koller (1994), Harley (2006), and Trice (1994) found that Pentecostal Christians endorsed a variety of causes that were often contradictory to one another. Specifically, they endorsed circumstantial, biological, and spiritual causes. However, the Pentecostals in Koller’s study believed in physical and spiritual causes for a variety of mental health disorders. Those in Trice’s study
endorsed stressful circumstances outside of one’s control, as well as demon possession as the most likely to cause major depressive disorder. In addition, Pentecostals in Harley’s study believed that stressful circumstances, demonic forces, and biological factors caused major depressive disorder and believed that demonic forces, chemical imbalances in the brain, and stressful circumstances caused schizophrenia. In addition, the Pentecostal clergy in Koller’s study endorsed the belief that sin was a cause of mental illness, including alcoholism, and anxiety and panic were the result of not trusting the Lord. Similarly, both the clergy in Azlin (1993) and Gaston (2000)’s studies embraced the biological and psychosocial, as well as the spiritual (demonic influences, spiritual conflict) as possible causes.

The Apostolic Pentecostal clergy’s belief that mental health disorders were not caused by spiritual problems was in accordance with the beliefs of Methodist clergy that individual or explicit religious reasons did not play an important role in mental illness (Lafuze et al., 2002). This divergence from what other researchers have found with Pentecostals could be viewed as particularly significant by outside observers, given the information in the literature review stating that Pentecostals believe in the existence of evils spirits and the Apostolic Pentecostals’ self-acknowledged spiritual worldview.

However, these results were not surprising to the researcher and simply provided support for anecdotal evidence. In the researcher’s 35 plus years of being immersed in the Apostolic Pentecostal culture, she rarely heard of parishioners or clergy attributing mental health disorders to spiritual factors. Although it is common knowledge in the religious world that Pentecostals believe in the existence of evil spirits, there has been little research discussing the way this belief is experienced and lived out in everyday life. As the subsequent issues discuss, part of this can be viewed in the context of the stronger emphasis Pentecostals place on God’s Spirit in
their lives. Yes, Apostolic Pentecostals acknowledge the existence of Satan and evil spirits, yet there is more emphasis on God being with the believer, rather than, as one clergy member described, on “chasing demons.” Thus, Pentecostals believe that evil spirits exist, but they do not believe they influence or cause mental health disorders. This is an example of their shared meaning making.

In addition, Apostolic Pentecostals stressed the integrated aspects of humans as physical, emotional, mental, and spiritual. Thus, they may view physical, emotional, and mental issues as being caused by issues related to the physical, mental, and emotional dimensions. Although they acknowledge the spiritual influences of the world, they do not view mental health problems as being caused by spiritual factors. The Pentecostal clergy acknowledged that in the past, identifying mental health problems as the result of spiritual factors was incorrect. They believed that spiritual issues could be attached to mental health issues—a view supporting their belief that humans are complex—but did not cause their mental health problems.

Looking at this from an ecological counseling perspective, we can see that as society and culture around them in the larger macrosystem of American understanding of mental health disorders changed, these Apostolic Pentecostals’ meaning making processes shifted as well. They incorporated the understanding that mental health disorders were not caused by mental health disorders into their beliefs.

**Beliefs Regarding Treatment of Mental Health Disorders**

The findings of endorsing mental health care and spiritual care were in contrast to the studies (Koller, 1994; Harley, 2006; Trice, 2003) that found Pentecostals preferred faith-based treatments to secular mental health treatments, wanted first to seek help from family and friends, and were often resistant to medication. In addition, these results differed from the
Pentecostal clergy in Koller’s study who believed that traditional treatments for mental illness were not compatible with Pentecostal Christian beliefs, that they should not seek help from non-Christian mental health professionals, and that mental health disorders could be treated by religious practices (1994).

The findings are congruent with studies where clergy supported the use of secular therapies (including prescription medication) in combination with faith-based therapies and preferred to refer to Christian mental health professionals (Azlin, 1993; Gaston, 2000; Lafuze et al., 2002). Although all of the clergy supported the use of medication, they did express the importance of medication not being unnecessarily prescribed and/or used to mask symptoms of mental health disorders. This was tied into their beliefs of recognizing all aspects of an individual. This thought was congruent with an identified theme with Pentecostals in Koller’s study (1994) that found that they also believed that the mind, the soul, and the spirit are integrated within a person.

The overriding theme of healing evident throughout the conversation of treatment is easily understood in connection to the Apostolic Pentecostals’ spiritual worldview. Every part of the life of an Apostolic Pentecostal—the physical, the emotional, the mental—is connected to the spiritual—the Spirit of God interacting personally with his/her human spirit. Thus, the spiritual realm is as real and vital to the life of an Apostolic Pentecostal as the natural realm. Although these believers exist and function in the natural world, they also acknowledge and highly value the spiritual world. Thus, treatment of mental health problems must be considered within the context of the whole person. These aspects of the believer—the mind, the soul, and the spirit—cannot be separated. They influence one another and must be addressed together to experience complete healing.
The discussion of treatment in the context of healing is also central to the Apostolic Pentecostal worldview that incorporates healing into their beliefs. Pentecostals believe that healing is available to believers. This supports Belcher & Hall’s assertion that “many Pentecostal clients approach counseling with the assumption that there is an acceptance of healing by the Christian counselor” (2001, p. 63). However, they understand that even though it is available, it is not guaranteed. Thus, Apostolic Pentecostals make provision for healing, asserting that God does not always answer in the manner in which individuals understand or expect. They affirm that faith in Jesus is key to receiving healing, yet regardless of the person’s faith, healing may not occur within this lifetime. It is recognized that medicine and the skills of medical professionals can ultimately be part of God’s healing. God can heal with medical help, but He can also heal miraculously without any human assistance (Alexander, 2006; Assemblies of the Lord Jesus Christ, 2012; United Pentecostal Church International, 2011; Warrington, 2006, 2008).

Just as they believe that God can heal other physical health issues, they believe that God can heal mental health issues. They believe that this can occur as an instant miracle or as a healing process. Part of that process can be God working with clergy and mental health providers to bring complete healing to the whole person. This view that healing can include the healing of the Spirit along with mental health care disproves Belcher & Hall (2001)’s assertion that Pentecostals view healing as a “panacea” …and ignores “the need for psychological work that is often necessary in the recovery process.” (p. 72). This idea of treatment as a healing process that utilizes mental health professionals, clergy, and God explains their preference for a counselor with a Christian background, or a background that embraces God. Since God is involved in all aspects of a person and their corresponding care, having a counselor who
does not acknowledge that view would be seen as hindering the Apostolic Pentecostal from obtaining complete health and wholeness.

Within their discussions of advocating for the inclusion of mental health care in addition to the working of the Spirit and spiritual care, they shared stories of people coming to them wanting to only trust God and pursue healing from Him and reject the mental health treatments of counseling and medication. They talked about encouraging believers that acceptance of faith and belief in God and utilizing mental health professionals do not have to be mutually exclusive. Thus, despite the clergy’s integrated view of the whole person and corresponding treatments, some of their parishioners might have difficulty reconciling when God does not heal them and their belief that He can.

These results may be reflective of the education level of the participants in this study. Six of them have college degrees, with three of them pursuing master’s degrees. Only one does not have an earned degree. Thus, overall they are an educated group. This education combined with their significant time in church ministry (Their range of licensed ministerial experience is 9 to 29 years, with an average of 19 years of experience.) may explain their shared view. They have spent time learning and experiencing the realities of life, including working with parishioners who have mental health issues, and have developed an understanding that mental health issues may need to be treated with the help of mental health professionals. Thus, they have endorsed counseling and medication, along with the working of the Holy Spirit and spiritual care of clergy.

**Roles of Clergy, Holy Ghost, and Mental Health Counselors**

The roles of clergy, the Holy Ghost, and mental health counselors working together to meet the needs of the whole person (the spiritual, emotional, mental, and physical) are an
extension of “how” this process of healing occurs and can be viewed in an ecological sense. Clergy saw their role was to provide spiritual care using supportive and faith-based interventions. They also discussed their role was to evaluate the problem, be led by God’s Spirit, and refer mental health issues to counselors.

The roles identified by the Apostolic Pentecostal clergy in this study were congruent with the results in Gaston’s (2000) study that found clergy viewed their role was to encourage the person to get help and refer them to a mental health professional, physician, or hospital. In addition, the clergy surveyed in his study reported that they listen carefully, assess the problem, offer emotional support, provide appropriate treatment, and follow up with the church member after their referral for additional help. The clergy in Gaston’s study had an understanding that mental illness was a legitimate medical concern and were able to recognize symptoms of mental illness. The clergy were aware of their own limits and reported that they provide initial support, offer referrals, and suggest other means for finding spiritual and emotional support within their church families.

However, a significant portion of the clergy in Gaston’s study reported that their challenge while ministering to those with mental illness was assessing the need of the person needing help. They wished to stay in their areas of expertise and were unsure the best course of actions to take as well as when to refer. The Apostolic Pentecostal clergy in this study did not give any indication that they had any problems knowing when to refer their parishioners to mental health professionals. They discussed talking with the members and when they determined a problem was a mental health issue, they would refer for outside help and based this on the leading of the Spirit. This “discernment” in determining the kind of problem and then proceeding to the appropriate modalities supports Belcher & Hall’s discussion of the use of
discernment in the healing theology of Pentecostals (2001). The Apostolic Pentecostal clergy in this study recognized their inability to treat the issue and need for professional help. This was in line with the ministers in Azlin’s (1993) study. She found that when clergy were aware of the complexity of the human psyche, they felt less competent to treat emotional issues. She also found a positive correlation in the number of people the pastor saw and the number of referrals they made to mental health professionals.

The Apostolic Pentecostal clergy views of the role of clergy are understood well within the context of their worldview. One clergy member’s description of the clergy being “Jesus with some skin on” is connected to their understanding that Pentecostals can be filled with God’s Spirit not just for salvation, but also for empowerment. Thus, they can be instruments to do the work of God, the work that Jesus did when He came to the world…the Word of God manifest in the flesh. Because believers are empowered from God with the Holy Spirit, they can be conduits of healing. This power is given to all believers. However, the clergy have responded to a call to commit their lives to ministering to the needs of individuals.

Becton, an Apostolic Pentecostal minister, (1991) said, “The preacher’s supreme task upon earth is ministering to the needs of the world and presenting the gospel to the lost and dying” (p.13). He asserted, “The minister must have a divine call directing him into a lifelong work for God” (p.15). This feeling, that the clergy are called by God to minister to the needs of people, is the reason that despite the clergy not treating the mental health issues themselves, they feel a great responsibility for their parishioners and see their role as providing necessary spiritual care while supporting the mental health care. As such, the clergy must be led by the Spirit of God when caring for their parishioners.
The clergy’s understanding of their role of being the spiritual guide for members, as well as being led by the Spirit is directly linked to the belief that the Holy Ghost works with clergy and mental health professionals to meet the needs of parishioners. In this sense, the Holy Ghost has a significant role not just by directly helping the believer, but also by empowering the healers as they help the member. This reflects the Apostolic Pentecostal’s belief in the Spirit as integral in all aspects of members’ lives as well as the idea that the Spirit is always working. In addition, this reliance on the Holy Spirit and their belief that they can be led by the Holy Spirit may reflect the implied confidence of being able to determine if a problem is rooted in mental health and needs additional help or if it is a spiritual problem needing their expertise. They acknowledged that people were complex and it is often difficult to determine the nature of problems. Thus, they seek guidance from God’s spirit to help them assist members.

The role of mental health counselors was seen as providing emotional/mental health care and working together with clergy. The clergy made a clear distinction between the mental health counselors acknowledging the importance of the spiritual aspect of humankind but not providing the spiritual care offered by clergy. This belief appeared to be connected to the clergy feeling responsible for their parishioners. Thus, the counselors providing spiritual care would indicate that they were not fulfilling their role. The clergy did not elaborate on the role of the counselors or the ways they take care of the emotional/mental problems. They simply acknowledged that counselors had the education and training in mental health issues and were thus better equipped to handle them. They spent much more time discussing the overall idea of clergy and mental health professionals working together to address the whole person and the importance of the mental health counselor being part of the care in addition to the spiritual.
Referrals to Mental Health Counselors

The referral practices shared in this study were similar to those seen in Gaston’s (2000) study. Ministers in his study reported making referrals to mental health counselors. They made more referrals and followed up with those who were referred. Gaston stated that this was particularly true for those mental health professionals who held similar religious views. As stated previously, the Apostolic Pentecostal clergy’s preference for a counselor who believes in God relates to their overall view of treatment in the context of healing. Their meaning making processes highlight that God works with the healers to bring complete health to members. If a healer in that process does not believe in God, it goes against their fundamental belief in the nature of the healing process.

In addition, clergy wanted those who were educated and had experience treating the issue for referral, as well as success in working collaboratively with clergy and churches. Clergy shared that they would send any problem they saw as a mental health issue to a counselor. They reported they would not send a problem that was viewed as a spiritual problem to a counselor. Spiritual problems were defined as those relating to the parishioners’ relationship with God and their eternal soul.

Once again, these descriptions are all in line with their overall views of problem identification, perceived causes of mental health issues, and treatment in the context of healing. Their endorsement of the importance of the counselors having the education, skills, and competency to treat mental health problems reflects on the clergy’s acknowledgement of the importance of utilizing those that are experts in their field as part of the healing instruments ultimately provided for by God. It would naturally follow that in addition to the counselor having a belief in God and the secular knowledge to treat the issues, having successful
relationships with churches and clergy would be integral in the collaborative nature of treatment that the clergy endorse.

**Important Things for Counselors to Know About Apostolic Pentecostals**

The clergy reported that it was important for the counselors to know that Apostolic Pentecostal Christians operate within the context of a faith-based worldview. Also, it was important that counselors know that past Apostolic Pentecostal teachings that viewed secular knowledge and modes of helping as unnecessary for those that had God’s Spirit still have an impact on both how they are perceived by some outside of the Pentecostal faith tradition, as well as how some Apostolic Pentecostals perceive getting outside help.

These results highlight the fact that Apostolic Pentecostals are deeply immersed in their spiritual worldview and are keenly aware that this is unique to them. They understand that there are equally devout individuals of other religious backgrounds. However, they also acknowledge their strong faith-based beliefs are not just a piece of their lives, but an integral part. These are directly tied into their distinct view of humanity not just being composed of the physical, mental, emotional, and spiritual, but the Spirit of God being active and central in the lives of humankind as well. They understand and function within this spiritual worldview.

For Apostolic Pentecostals, all of these aspects of humanity exist in an integrated whole person, and thus allow for the coexistence of the spiritual realm and the natural physical realm. They understand that on the surface there may be difficulty reconciling the belief in both of these worlds simultaneously, particularly because of the history of the antagonistic relationship between science and religion. This is evident in their discussions of it being important for counselors to know that the clergy did value education, outside help, and those things associated with the natural world in addition to the those things involved with the spiritual
realm and the preconceived notions by outsiders that this is not the case. It is also evident in those responses by clergy discussing the importance of counselors knowing that some Apostolic Pentecostals may have difficulty accepting additional help seen as natural alongside the spiritual. These are two sides of the coin, both indicating that people can have difficulty reconciling the seemingly contrasting parts of humanity and the world as a whole.

Collaboration

The clergy all said that they would collaborate with mental health professionals on meeting the needs of their parishioners and stressed the importance of doing so. This tied into their overall beliefs that mental health disorders should be treated by counseling and medication with concurrent spiritual care. The clergy believed that collaboration should involve clergy and counselors working together within their areas of expertise to meet the needs of the parishioners. This process entailed communicating, respecting one another, sharing ideas of how to treat the member, and respecting boundaries and confidentiality. Clergy shared that negating or not recognizing the spiritual component of the whole person would turn them and their parishioners off. This could be accomplished by directly discouraging their faith-based worldview and associated practices or indirectly by encouraging a humanistic point of view (understood as taking God out of the equation, that all power was within humanity).

As with their responses to other questions, these supported their beliefs in the importance of addressing the whole person with all modes of helping, stressing the complementary roles of the clergy and mental health counselors. They also highlighted their willingness to work with the counselor, with the understanding that there is mutual respect and they are both on the same page in their efforts to help parishioners. It also reiterated their belief that the counselor must have a basic belief in God, or at least not be anti-God. A counselor who would not accept and
work within the Apostolic Pentecostal Christian’s spiritual worldview would turn the members and clergy off and not be successful. The clergy were clear that if the counselor negated the importance of the spiritual realm or went directly against their faith-based practices they would not send their parishioners to them. Not only would this create problems for the clergy, it would create problems for the members. They acknowledged that this conflict would not be healthy for individuals and felt a personal responsibility for the lives of their members. Once again, these sentiments stress the high value and significance that Apostolic Pentecostals place on their faith.

The influence of the Pentecostal clergy’s religious culture is evident in the overall themes of the Apostolic Pentecostals’ beliefs regarding the causes of mental health disorders, their endorsed treatments, and who they entrust to provide the treatment, as well as their overall understanding of mental health disorders. Their shared experiences and theological beliefs uniquely shape their worldview and the meanings they derive from them. This shared identity of Apostolic Pentecostals as a religious cultural group was prevalent throughout the study.

**Implications for Counselors**

This discussion leads to several implications for practice. Counselors working with Apostolic Pentecostals need to recognize the complexity of their unique worldview that embraces the natural realm, yet also embraces and highly values the spiritual realm. This worldview influences the way they understand mental health issues and how they believe they should be addressed. As such, counselors need to practice within this worldview.

Counselors need to understand that Apostolic Pentecostals embrace all aspects of the natural and spiritual realms, both in the person and in the world in general. Thus, they view all aspects of a person—the physical, mental, emotional, and spiritual—as important. Therefore,
they believe in a balanced approach to care and believe that counselors should come from this approach as well. Counseling that is seen as neglecting or denying the spiritual aspect would be particularly problematic for Apostolic Pentecostals.

Counselors need to be aware that Apostolic Pentecostal clergy see a variety of mental health issues in their parishioners and feel a personal responsibility for supporting them. The parishioners in their congregations experience mental health problems common to others outside of their faith tradition. As such, there is a need for counselors to be comfortable and experienced in working with Apostolic Pentecostal Christians. Part of that work involves understanding that the clergy feel a responsibility for their members and feel the need to support them. Counselors will do well to understand this and encourage clergy to continue to support their members.

Counselors also need to recognize that Apostolic Pentecostal clergy endorse multiple causes for mental health issues including biological and psychosocial variables with an understanding of the role that personal differences plays. Counselors need to be aware that although they believe in the existence of Satan and evil spirits, this is observed rarely in American churches. They do not believe mental health issues are caused by evil spirits. Thus, Apostolic Pentecostals may operate within a worldview that allows for evil spirits, but their focus is more on the interaction of God’s Spirit with theirs, rather than on evil spirits. They do not believe evil spirits or spiritual problems cause mental health issues. Therefore, counselors working with Apostolic Pentecostals must understand that they view mental health problems originating from a variety of causes that are separate from spiritual problems that would be associated with problems with their relationship with God. Spiritual problems may come up in
the counseling relationship, but they are simply in the context of the whole person, not in the context of causing a mental health problem.

Counselors also need to be aware that clergy endorse both mental health counseling and psychotropic medication, with concurring spiritual care as important components to treatment. They believe that mental health issues should be treated with counseling, while acknowledging that some mental health disorders must also be addressed with medication. While these issues are being treated by mental health professionals, the clergy can support the person and their spiritual well being as part of the whole person. Counselors should feel comfortable in that clergy highly endorse counseling.

However, although all of the clergy endorsed the possible need for medication, there were a few who believed medication should only be a part of addressing the whole person and not just used as a sole treatment. Thus, they acknowledged it was necessary but felt it should not mask symptoms and prevent the members from also dealing with their problems within counseling. Therefore, the counselor may need to be aware of their caution and educate them on the best practice guidelines of the combination of medication with counseling. This information would be well received since it supports their belief in addressing the whole person.

In addition, counselors need to be familiar with the clergy’s view of treatment within the context of the view of healing. Clergy believe that God can heal any problem but often uses a healing process involving clergy, the Holy Spirit, and counselors. God is always viewed as being involved in that process, but He also uses clergy and counselors to accomplish this process often with the help of the Holy Spirit. From the clergy’s perspective, the counselor treats the mental health problem and works with the clergy who is providing spiritual care to help the parishioner obtain complete healing—mentally, emotionally, physically, and
Apostolic Pentecostal Christians are spiritually engaged. The Holy Spirit is viewed as available to help the clergy and the counselor in their efforts to facilitate healing for the believer.

Thus, counselors working with Apostolic Pentecostal Christians practice with the understanding that they are not responsible for the spiritual concerns of the individual. The spiritual role is entrusted to their clergy. Counselors can focus on interventions grounded in best practices which acknowledge the spiritual aspect of the individual, while realizing that area will be addressed by the clergy. In addition, it would be helpful to acknowledge the important role of the clergy in the parishioners’ lives. This could be accomplished by allowing them to feel comfortable sharing the spiritual part of their lives, as well as by including the clergy in coordination of caring for the member.

Counselors need to know that clergy prefer referring their parishioners to mental health counselors who have a Christian background, or at least have a belief in the existence of God. They will not refer to a counselor that they know is an atheist or anti-God. Thus, counselors who embrace a belief in God would be the best match for Apostolic Pentecostal Christians, with a preference for counselors with a Christian background. Counselors do not have to practice Christian counseling or even advertise as Christian counselors. They just need to come from a background that acknowledges the existence of God and does not work against their Christian worldview. Therefore, counselors should not take offense to Apostolic Pentecostal Christians inquiring about their personal belief system. They do not expect the counselor to provide pastoral care or agree with their specific views, they merely want to feel that the counselor understands and respects where they are coming from as a Pentecostal.

In addition, the clergy want to refer to counselors who are educated, well trained, have experience in treating the issues, and have successful relationships with clergy and churches.
Thus, the clergy place a high value on spirituality. Yet, they also expect the counselor to be an expert in their field and have demonstrated success working collaboratively with clergy. Thus, the counselors should display a balance of providing appropriate mental health care while demonstrating the ability to work with clergy.

Clergy would like to collaborate with counselors who embrace the importance of their spiritual worldview. This is something that the clergy would love to see happen and it has not happened in the past. They would like to work together with the counselor on addressing the needs of their parishioners. They would love this to be an ongoing relationship based on mutual respect and trust. They would appreciate being recognized as experts in their field and would reciprocate the same respect to counselors. Within respecting the boundaries of confidentiality and ethical behavior, they would like to have ongoing communication with counselors in order to coordinate care, as well as reinforce and support the interventions of the counselor. They would be open to the exchanging ideas of how to meet the needs of the parishioner.

The only things that would turn Apostolic Pentecostals off to collaborating with counselors would be the counselors directly negating or discouraging the importance of their spiritual beliefs and faith-based practices or indirectly pushing a humanistic approach that takes God out of the picture. As such, counselors should take advantage of the opportunity to incorporate a very influential person in an Apostolic Pentecostal’s life, his or her clergy.

The clergy’s obvious desire to collaborate with counselors on meeting the needs of their parishioners should be considered by counselors. The Apostolic Pentecostal clergy are not aware of the ways in which they can collaborate with counselors because they have often been left out of the helping process. The findings of this study indicate that they see counselors and clergy as important instruments in the healing process of treating mental health disorders.
such, it would behoove counselors to reach out to Apostolic Pentecostal clergy members and discover ways they can help the clergy meet the needs of their parishioners. This reaching out could help counselors understand the Pentecostal worldview, encourage Pentecostals to seek help when needed, allow the clergy to feel valued and appreciated in their role of helping, and facilitate ways that counselors and clergy could work together on addressing mental health issues. This could also provide educational opportunities for each to learn the expertise of the other.

In addition, it is important to pay close attention to those things they identified would be important for counselors to know about Apostolic Pentecostal Christians. First, Apostolic Pentecostal Christians operate within the context of a faith-based spiritual worldview. Counselors must understand that Apostolic Pentecostals greatly value the Spirit of God and the Word of God in their lives. God is at the center of all aspects and they highly regard their faith. This worldview is a strength that counselors should embrace and work with in order to have a successful counseling relationship.

Second, counselors need to know that the past Apostolic Pentecostal teachings that viewed secular knowledge and modes of helping as unnecessary for those that had God’s Spirit still have an impact on both how Apostolic Pentecostals are perceived by some outside of the faith tradition, as well as how some Apostolic Pentecostals perceive getting outside help.

Counselors must be aware that the clergy no longer endorse these teachings and embrace education and outside help. They encourage their members to seek outside help. However, counselors need to be aware that the impact of those teachings may still linger in Apostolic Pentecostals and counselors may need to encourage members that it is okay to seek additional help. Some Apostolic Pentecostal Christians might have difficulty with needing additional help.
beyond the Holy Spirit. Counselors need to understand that Apostolic Pentecostals can believe in a spiritual realm and embrace the natural realm. They can embrace the help of the Holy Spirit and their clergy, while incorporating the help of counselors. These are not seen as mutually exclusive.

Thus, counselors must be sensitive to preconceived notions that clergy are fighting against, both with those outside of the faith tradition as to what their true beliefs are, as well as with their parishioners that are struggling to reconcile the idea that spiritual help and secular help can work together. Therefore, counselors should not make assumptions and should ask the clergy and the parishioners their views regarding this sensitive subject.

Finally, counselors need to be educated on the complexities often found within religious cultures. As the findings of this study indicate, religious cultures are embedded in their shared history, yet remain dynamic and fluid. The Apostolic Pentecostal clergy in this study were very aware of their shared history and past teachings that have shaped their worldview. They were also aware and concerned of preconceived notions that counselors could hold regarding their views on mental health and secular knowledge. Thus, counselors must learn and embrace the complexities of shared histories, the meaning individuals make from them, and how cultures are dynamic and fluid.

**Limitations**

This study was an exploratory study with a limited sample size. Results of this study cannot be generalized to the entire Apostolic Pentecostal clergy community because only seven individuals were interviewed. Considering the number of Apostolic Pentecostals in the United States, the views of seven people may not be a representative sample of the population. Another set of participants may respond differently to the questions and present different themes other
than those identified in this study. Since the researcher is an Apostolic Pentecostal, she acknowledges her own biases in making judgments and interpretations from what the participants said. It would be difficult for a researcher to duplicate this study because of the researcher’s experience as a mental health counselor within the Apostolic Pentecostal community, her involvement in ministry, and her connection with many Apostolic Pentecostal clergy. Another researcher with a different background than the researcher could draw different conclusions than those identified in this study. In addition, the clergy in this study may have been more open to working with mental health counselors.

The fact that the participants were not completely randomly selected is a limitation. Emails were sent out soliciting respondents from a pool of individuals that the researcher knew were practicing Apostolic Pentecostal clergy members. As a result, the participants were connected in some way in varying degrees to the researcher because of the shared experience of being Apostolic Pentecostal. For example, two participants were acquaintances that the researcher originally met more than fifteen years ago and does not have current relationship with them. Three participants were ministers the researcher had never met; they were friends with acquaintances met in a similar fashion as the aforementioned. Two of the participants were closer acquaintances. These connections could cloud the facts shared and the way they were interpreted. Although this bias may exist, the researcher felt that the benefits of the study outweighed the bias due to the paucity of research on Apostolic Pentecostal clergy and the insider outsider mentality that Apostolic Pentecostals may have.

Although the researcher wanted to balance the racial composition of the participants, it was difficult to get this balance. The results may have a Caucasian slant because the Caucasian participant outweighed the minority participant six to one. The researcher sent out emails to
other minority clergy members of whom she was aware. However, overall she knew more
Caucasian clergy. She would have liked to have more African Americans represented in the
sample, as well as Hispanic clergy and other minorities, especially since Apostolic Pentecostals
are a very racially diverse group. In addition, there was only one female minister. Thus, there is
obviously more of a male perspective. However, there are significantly more male ministers in
the Apostolic Pentecostal faith tradition than female ministers. The researcher is not aware of
the actual ratio.

**Implications for Future Research**

Future research of Apostolic Pentecostal clergy could include a broader pool of
participants. Simply increasing the number of participants would be one focus. In addition,
having participants with a variety of demographic variables, including gender, age, ethnicity,
education level, geographical location, and ministerial organization would be helpful. Since
Apostolic Pentecostals are a very diverse group of people, it would provide a more
representative sample, as well as investigate if there are any within group differences.

This study could be quantitative in nature to get a broader picture and look at differences
between demographic variables. Alternatively, the study could be qualitative in nature and
could analyze the results using an ecological counseling perspective and look at the interaction
of the person and his or her environment and how the meaning he or she ascribes to them affects
beliefs about mental health disorders.

Another study could focus on a deeper exploration of the past teachings that asserted that
if believers had the Holy Spirit, they should be emotionally, mentally, spiritually, and physically
healthy, and how these teachings have shaped their worldview and current understandings of
mental health. Clergy could be interviewed about their concerns and what they see are
preconceived notions about Pentecostals. Mental health counselors could be interviewed to see what their current understandings are regarding Pentecostals and mental health. Results could be compared and used to discover implications for practice.

Since the Apostolic Pentecostal clergy in this study did not view evil spirits as causing mental health issues, a study exploring this topic with other Apostolic Pentecostal clergy would be beneficial to see if this was reflective of the population as a whole. The research could focus on how the view of the world of spirits is experienced in today’s culture of Apostolic Pentecostals, while noting any differences based on various demographic variables. In addition, exploring the topic with parishioners would be helpful to explore their understanding of the spiritual realm and its relationship to mental health issues.

Next, a study that focused on specific ways counselors could collaborate with clergy would yield practical ways to begin successful collaboration. This could include interviewing both mental health counselors and clergy. Both could be interviewed about resources that would be helpful in merging the two disciplines to best meet the needs of individuals, as well as what would be viewed as successful collaboration.

Another interesting study would be to explore both Apostolic Pentecostal clergy and Apostolic Pentecostal parishioners’ beliefs and see if they shared the same beliefs and understandings of mental health disorders. The clergy in this study indicated that they often had to encourage their parishioners that it was okay to get additional help outside of the Holy Spirit and the clergy to meet mental health disorders, as well as accepting the necessity and benefit of psychotropic medication. This study would be beneficial for clergy as well as counselors to understand how Apostolic Pentecostal parishioners view mental health disorders.
Finally, a study that explored the Apostolic Pentecostal clergy’s definitions of mental health problems and spiritual problems and how they are similar or different would be helpful in understanding their worldview. This could also include an exploration of the concept of “discernment” and how this is used to help determine the nature of a parishioner’s problem.

**Conclusions**

Apostolic Pentecostals experience mental health issues common to those of other faith traditions. However, they espouse a unique worldview that is complex and embraces the natural realm while embracing, and highly valuing, the spiritual realm. Apostolic Pentecostals’ unique spiritual worldview influences their beliefs and practices related to mental health disorders. Specifically, researchers (Koller, 1994; Harley, 2006; Trice, 2003) have found that Pentecostals present a shared view of what they believe causes mental health disorders, how they should be treated, and those they trust to provide treatment. These researchers found that overall, Pentecostals embraced a variety of causes for mental health disorders, including circumstantial, biological, and spiritual. They also found that they believed they should be treated with faith-based treatments and they preferred to seek help from clergy, family, and friends, in lieu of mental health professionals. In addition, studies have shown that clergy often hold different beliefs regarding mental health disorders.

The Apostolic Pentecostal clergy interviewed in this study displayed a shared view of mental health disorders. Their beliefs regarding mental health disorders were in some ways similar to past studies. For example, the Apostolic Pentecostal clergy discussed the importance of viewing the whole person including mind, body, and spirit. They also discussed treatment for mental health disorders in terms of healing from God. However, they differed significantly from other studies. The Apostolic Pentecostal clergy embraced a variety of causes for mental
health disorders, but did not believe spiritual factors caused mental health disorders. In addition, they discussed at length how God can heal an individual, but can accomplish this through a process facilitated by clergy, the Holy Spirit, and mental health professionals working together. As a result, they endorsed the mental health modalities of counseling and medication in addition to the work of the Holy Spirit and spiritual care provided by clergy. Also, the clergy in this study placed trust in mental health professionals who would embrace their spiritual worldview and collaborate with them on meeting parishioners’ needs.

This study highlights the need for counselors to be aware of the way that culture affects beliefs regarding mental health disorders. This can be understood in the context of religion as an important cultural variable. Specifically, this study indicates that Apostolic Pentecostal clergy have shared views reflective of their worldview. Counselor must also be aware that religious cultures are often complex and are dynamic and fluid.

Counselors must understand where individuals have been and where they are in order to help them reach the place they desire to be in the future. This is particularly true with Apostolic Pentecostal Christians, as well as the clergy that are highly invested in their well-being.

Future research should focus on exploring these issues further, to get a more complete picture of the way Apostolic Pentecostal clergy, as well as Apostolic Pentecostal parishioners view mental health disorders in order for counselors to help meet their needs. This research could include the exploration of ways that problems are identified and distinguished, the role of demographic variables within the culture, the impact of past teachings on their worldview, how they currently experience and understand the spiritual realm, ways that clergy and parishioners beliefs may be similar and different, and specific ways for counselors to collaborate with clergy on meeting the mental health issues of their parishioners.
References


Appendices

Appendix A

Recruitment Email
Recruitment Email

Volunteers Needed for a Research Study
“Apostolic Pentecostal Clergy Beliefs Regarding Mental Health Disorders”

Hello,

I am contacting Apostolic Pentecostal clergy over the age of 18 for participation in my dissertation research study. The purpose of the research study is to assess the Apostolic Pentecostal clergy’s beliefs regarding mental health disorders. This study seeks to gain an understanding of the Apostolic Pentecostal clergy’s current beliefs regarding the causes and treatments for mental health issues. It also seeks to assess current counseling practices and endorsed treatments used to meet the mental health needs of church members.

The study involves participating in a telephone interview that will last approximately 30 to 45 minutes and will be recorded.

You will not be reimbursed for your time. However, results of the study will be available to you once the study is completed.

Your participation is voluntary and is confidential. If you do not wish to participate in the study, you may still request a summary of the findings after the study is complete.

If you are willing to participate:

- Please read the enclosed Information Sheet
- Respond to this email and provide the following information
  - Your age
  - The organization that issued your minister’s license
  - A phone number where you can be reached for the interview
  - Best day and time to reach you for the interview.

If you are interested and willing to participate, please read the attached Information Sheet and reply to this email. If you have questions, please contact me at hardwikl@mail.uc.edu. You may also contact my faculty advisor, Dr. Ellen Cook, at cookep@ucmail.uc.edu. Depending on the number of responses, you may or may not be selected as a participant.

BY RESPONDING TO THIS EMAIL, YOU ACKNOWLEDGE THAT YOU HAVE READ THE ATTACHED INFORMATION SHEET, AGREE TO PARTICIPATE IN THE TELEPHONE INTERVIEW, AND INDICATE YOUR CONSENT FOR YOUR ANSWERS TO BE USED IN THIS RESEARCH STUDY.

Sincerely,

Kristy L. Hardwick, M.A., PCC, Principal Investigator
Doctoral Candidate
University of Cincinnati, Counseling Program
Appendix B

Information Sheet for Research
Information Sheet for Research

University of Cincinnati
College of Education
School of Human Services
Counseling Program
Principal Investigator: Kristy L. Hardwick
Faculty Advisor: Ellen P. Cook

Title of Study: Apostolic Pentecostal Clergy Beliefs Regarding Mental Health Disorders

Introduction:
You are being asked to take part in a research study. Please read this paper carefully and ask questions about anything that you do not understand.

Who is doing this research study?
The person in charge of this research study is Kristy L. Hardwick of the University of Cincinnati (UC) College of Education, School of Human Services, Counseling Program. She is being guided in this research by Dr. Ellen P. Cook.

What is the purpose of this research study?
The purpose of this research study is to assess the beliefs regarding mental health disorders and the practices of Apostolic Pentecostal clergy. This study seeks to gain an understanding of the Apostolic Pentecostal clergy’s current beliefs regarding the causes and treatment preferences for mental health issues within their congregations. It also seeks to assess current counseling practices and endorsed treatments used to meet the mental health needs of church members.

Who will be in this research study?
About 8 people will take part in this study. You may be in this study if

- You are an adult over the age of 18 and
- You are a licensed minister by a recognized Apostolic Pentecostal Organization

What will you be asked to do in this research study, and how long will it take?
You will be asked to participate in an interview. It will take about 30 to 45 minutes. The interview will take place by telephone. You will be asked to provide demographic information including your gender, age, number of years as a licensed minister, size of your congregation, state of residence, and training in mental health issues and counseling. You will also be asked about your beliefs regarding the causes and treatments of mental health disorders and counseling practices. The interviews will be recorded to assist in data analysis.

Are there any risks to being in this research study?
It is not expected that you will be exposed to any risk by being in this research study.

Are there any benefits from being in this research study?
You will probably not get any benefit from taking part in this study. However, being in this study may help mental health professionals understand Apostolic Pentecostal clergy’s beliefs regarding the causes and treatments of mental health disorders, as well as provide important information to help meet the mental health needs of Apostolic Pentecostal Christians.

**What will you get because of being in this research study?**
You will not be paid to take part in this study.

**Do you have choices about taking part in this research study?**
If you do not want to take part in this research study you may choose to not participate.

**How will your research information be kept confidential?**
Information about you will be kept private by limiting access to research data to the research team, erasing audiotapes after they are transcribed, not including your name on the typed transcript, and keeping research data in password-protected files on a password-protected computer.

Your information will be kept in a locked drawer in faculty advisor’s office for two years. After that it will be destroyed by shredding paper research files. Any computerized records will also be deleted.

The data from this research study may be published; but you will not be identified by name.

Agents of the University of Cincinnati may inspect study records for audit or quality assurance purposes.

The researcher cannot promise that information sent by the internet or email will be private.

**What are your legal rights in this research study?**
Nothing in this consent form waives any legal rights you may have. This consent form also does not release the investigator, the institution, or its agents from liability for negligence.

**What if you have questions about this research study?**
If you have any questions or concerns about this research study, you should contact Kristy L. Hardwick at hardwikl@mail.uc.edu. Or, you may contact Dr. Ellen P. Cook at cookep@ucmail.uc.edu.

The UC Institutional Review Board reviews all research projects that involve human participants to be sure the rights and welfare of participants are protected.

If you have questions about your rights as a participant or complaints about the study, you may contact the UC IRB at (513) 558-5259. Or, you may call the UC Research Compliance Hotline at (800) 889-1547, or write to the IRB, 300 University Hall, ML 0567, 51 Goodman Drive, Cincinnati, OH 45221-0567, or email the IRB office at irb@ucmail.uc.edu.

**Do you HAVE to take part in this research study?**
No one has to be in this research study. Refusing to take part will NOT cause any penalty or loss of benefits that you would otherwise have.

You may start and then change your mind and stop at any time. To stop being in the study, you should tell Kristy Hardwick at hardwikl@mail.uc.edu

BY RESPONDING TO THIS EMAIL AND PARTICIPATING IN THE TELEPHONE INTERVIEW YOU INDICATE YOUR CONSENT FOR YOUR ANSWERS TO BE USED IN THIS RESEARCH STUDY.

PLEASE KEEP THIS INFORMATION SHEET FOR YOUR REFERENCE.
Appendix C

Interview Guide
Interview Guide

1. Are you male or female?

2. What is your age and race?

3. What organization is your minister’s license from? How long have you been a licensed minister? Were you ever licensed through another organization? If so, which one?

4. What is your title? (Bishop, Senior Pastor, Assistant Pastor, Youth Pastor, Evangelist?)

5. How many members do you have in your congregation? How would you describe the socioeconomic makeup of your congregation? In what state is your church located?

6. What kind of training have you had to prepare you as clergy? What kind of training have you had in counseling and/or mental health issues?

7. What types of mental health issues have you seen in your members? What kinds of symptoms/behaviors did they exhibit?

8. What are the causes of these mental health issues? What are the causes of other mental health issues?

9. How should these mental health issues be treated/resolved?

10. What are the roles of clergy, the Holy Ghost, and mental health counselors in treating these mental health issues?

11. Do you counsel with church members who are experiencing mental health issues? Why or why not?

12. If you have worked with parishioners with mental health problems, what types of interventions have you used to address these mental health issues?

13. Have you ever referred a member to a mental health counselor? What characteristics of a mental health counselor would be needed in order for you to feel comfortable with such a referral? What kinds of problems/issues would initiate a referral? Are there any types of problems that you’ll never send to a mental health counselor?

14. What would be important for a mental health counselor working with an Apostolic Pentecostal Christian to know?

15. Would you collaborate with a mental health counselor in meeting these needs? What would this look like? What might a mental health counselor do that would likely “turn you (and your parishioners) off?”