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Seventh-day Adventist Caribbean Pastors' Experiences in Addressing Their Parishioners' Mental Health Consultations

Donnet Ivorine O'Connor
Walden University

Walden University

College of Psychology and Community Services

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Donnet O'Connor

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Review Committee
Dr. Susana Verdinelli, Committee Chairperson, Psychology Faculty
Dr. Silvia Bigatti, Committee Member, Psychology Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

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Abstract

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MA, International College of the Cayman Islands, 2015

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Abstract

Some people trust the clergy more than medical and psychological professionals when dealing with mental health issues due to the stigma attached to mental health, the low cost or free service, trust, cultural misunderstandings, and easy access. However, a major problem can arise when people turn to the clergy instead of professionals because they may not know that they can be harmed or misinformed about their problems. On the clergy's side, counseling people who may need professional assistance may put clergy at risk of facing legal and ethical allegations. Research on Seventh-day Adventist clergy and how they address mental health consultations for their parishioners in the Caribbean is limited. Thus, the purpose of this phenomenological study was to understand how pastors from the Seventh-day Adventist Church address their parishioners' mental health consultations and explore the training they received before addressing these consultations. The social exchange theory was used as the basis for this study. Ten pastors participated in the semi-structured interviews. Thematic analysis was used to analyze the data from the interviews. According to the results of this research, pastors do everything in their power to assist parishioners with their mental health consultations. Family related issues are the most frequent consultation. Study findings can bring about positive social change as pastors can use it in planning church activities, sermon presentations, and collaborating with experts and organizations to develop programs that address these areas of concern. Pastors can become aware that referring parishioners to trained professionals is helpful, and, by extension, society can understand the importance of involving specific trained personnel in dealing with mental health issues.

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Table of Contents

List of Tables

Chapter 1: Introduction to the Study

In this phenomenological study, I focused on Seventh-Day Adventist Caribbean pastors' experiences in addressing their parishioners' mental health consultations. Parishioners' consultations with their pastors are known to be a global phenomenon, especially among the Afro-Caribbean, African American, and colored people worldwide (Eliason et al., 2013; Hibbert, 2023). In fact, the use of clergy for mental health consultations is so prominent that many researchers have referred to them as gatekeepers for mental health treatment (Brown & McCreary, 2014; Heseltine-Carp & Hoskins, 2020; Payne & Hays, 2016). However, to deal with mental health issues, the clergy needs to have the necessary competency to recognize mental health problems and address them or refer individuals to appropriate care (American Psychological Association [APA], 2019). A pastor is trained in theology and leads a church as a spiritual leader. Without the proper training, the clergy will not be able to effectively address mental health and preserve their safety and the safety of their parishioners.

The purpose of this study was to understand how pastors from the Seventh-day Adventist Church address their parishioners' mental health consultations and to explore pastors' training to address these consultations. I focused on Seventh-Day Adventist pastors due to the fast growth and strong faith of this church in the Caribbean and the influence of the clergy on such a large group of the population (see General Conference of Seventh-day Adventists, 2015; Heck et al. 2018). Results of this study may provide information on the training needs pastors may face in addressing mental health consultations. Giving visibility to pastors' training needs may be used to revise policies

and training of the governing organizations. In turn, adjusting training to pastors' needs may have substantial benefits for the church members. Informed pastors can provide better service to the congregation. In this chapter, I include the background for this study, an outline of the theoretical framework selected, the problem statement, a discussion of methodological procedures, and limitations of the study. Finally, I discuss the significance and potential of this study for unique social change.

Background

The preponderance of literature on clergy and mental health have focused on the reality of the clergy being the gatekeepers for mental health treatment (Brown & McCreary, 2014; Heseltine-Carp & Hoskins, 2020; Payne & Hays, 2016). Other articles have focused on the stigma, cost, accessibility, and trust associated with individuals' preference to seek help from clergy instead of help from mental health professionals (Brown & McCreary, 2014; Chevalier et al., 2015; Jones et al., 2012). The phenomenon of clergy being the gatekeepers of mental health treatment is widely accepted across many countries (Ayvaci, 2016; Crosby & Bossley, 2012; Derr, 2016; Kirk, 2018; Leavey, 2010). Brown and McCreary (2014) conducted a study on the nature of the consultations that are taken to the clergy, and found that sex, drugs and alcohol abuse, and domestic abuse are some of the sensitive issues that were not discussed as they were considered too immoral to discuss with the clergy.

Payne's contribution to research on the clergy and their involvement in mental health is very extensive (Payne, 2014; Wright, 2021). In his work, Payne found evidence that suggested that a large number of clergies lacked formal training in specific areas and

did not consider themselves equipped to deal with mental health issues. Payne stated that training and education in mental health are what the clergy needs to be effective in helping with mental health issues (Payne, 2013; Wright, 2021). Other researchers wrote about the boundary issues that clergy can encounter if they are not trained to manage many of the matters that they encounter in their line of work. These boundary issues include dual relationships, sexual attraction, confidentiality issues, and counseling competency (APA, 2020; Eliason et al., 2013; Fisher, 2021; Guo et al., 2011).

The bulk of extant research regarding clergy and parishioners' mental health consultations does not include the Seventh-Day Adventist church. The Seventh-Day Adventist church is the second largest church in the world, with a membership of 21,912,161 served by 20,924 active pastors worldwide (Seventh-Day Adventist Statistic, 2021). However, research on the consultation with the Seventh-Day Adventist clergy is scarce. There is a need to understand how pastors from the Seventh-Day Adventist church address their parishioners' mental health consultations and to explore pastors' training to address these consultations. It is necessary to understand how such a large population is helped when the clergy is consulted.

Problem Statement

Many researchers have referred to the clergy as gatekeepers of mental health treatment (Brown & McCreary, 2014; Heseltine-Carp & Hoskins, 2020; Payne & Hays, 2016). Some people trust the clergy more than medical and psychological professionals when dealing with mental health issues because of the stigma attached to mental health consultations (Brown & McCleary, 2014; Chevalier et al., 2015; Jones et al., 2012).

Other reasons for favoring clergy over professionals include low cost or free service, trust, cultural understandings, and easy access given that churches can be found everywhere (Allen et al., 2010; Campbell & Littleton, 2018). Factors that deter parishioners from accessing the clergy's counseling services are sensitive areas of concern, including sex-related issues, drugs and alcohol abuse, and domestic abuse. Parishioners may consider it immoral or inappropriate to discuss these issues with a religious person (Brown & McCreary, 2014; Zarb-Cousin, 2020).

The problem addressed by this research was the lack of knowledge on how the Seventh-Day Adventists pastors address the mental health consultations of their members and how prepared they are for such role. Many studies have shown that as many as 40% of Americans use the clergy when experiencing mental difficulties (Crosby & Bossley, 2012; Derr, 2016; Kirk, 2018; Leavey, 2010). More specifically, Ayvaci (2016) surveyed 306 patients from 13 health facilities in Los Angeles and discovered that 80% of this group use religion to cope with their daily difficulties, and 20% of this 80% use the clergy to deal with their difficulties. However, problems arise when people turn to clergy instead of mental health professionals for assistance with mental health issues. People do not know that they can be harmed or misinformed about their problems. For clergy, counseling people who may need professional assistance may put them at risk for legal and ethical allegations (APA, 2017; Eliason et al., 2013; Guo et al., 2011). Research has been conducted on various aspects of clergy and their counseling habits, expectations, beliefs, attitudes, and limitations (Avent et al., 2015; Campbell, 2021; Exline, 2021;

Smith et al. 2018). However, existing research has focused on data gathered in the United States, even when other cultures are being studied (Vernaas et al., 2017).

Research on clergy and how they address their parishioners' mental health consultations in the Caribbean is limited not just in the Adventists church but in varied denominations. An examination of how pastors of the Seventh-Day Adventist Church in the Caribbean address their parishioners' mental health consultations can provide meaningful insight into the quality, lack, or even the dangers of such practices. Results of this study can shed light into what their experiences are and how prepared they may be for such role.

Purpose

The purpose of this phenomenological study was to understand how pastors from the Seventh-Day Adventist church address their parishioners' mental health consultations and to explore pastors' training to address these consultations. Participants for this study were pastors who served in two unions. A union consists of a group of churches making up a conference. The two unions included in the present study were located in the Caribbean, specifically the Bahamas Islands, Cayman Islands, Turks and Caicos Islands, and Jamaica. The Atlantic Caribbean Union has five conferences, and the Jamaica Union has four. The commonality among these unions is that together, they own one seminary for training pastors, which is situated in Jamaica and called the Northern Caribbean University. The pastors of this region are trained at this university and have similar counseling competencies, unless they choose to do further studies.

Research Questions

The central research questions (RQs) in this study were as follows:

RQ1: What are the Seventh-day Adventist Caribbean pastors' experiences in addressing their parishioners' mental health consultations?

RQ2: How do Seventh-day Adventist Caribbean pastors describe the training received to serve their parishioners' mental health consultations?

Theoretical Framework

I used social exchange theory to ground my study. This theory purports that the parties in a relationship are motivated by the benefits the relationship is expected to bring (Blau, 1964; Cook et al., 2021). Thus, with an equitable valuable exchange, the clergy and the parishioners see this synergetic relationship considerably sustaining for both parties. Parishioners receive favorable benefits from the clergy and are satisfied with the outcome. The outcome is that parishioners are helped with their consultations; they do not have to pay, they do not need insurance, they trust their pastor, and there is no stigma attached to seeing him, which is quite the opposite when they see a mental health professional (Chevalier et al., 2015; Payne, 2008, 2014; Sutton, 2023).

The clergy also benefits from taking care of the parishioners' consultations. Pastors have reported that their members are their social support. They are a family who looks out for its members and is concerned for them and their well-being (Hough et al., 2019; Eproson Jr., 2021). The clergy has also reported that they are quite content when they know that their help with congregants is by professionals who practice Christ-centered therapy, and they know those professionals well and trust their approach to

mental health (Bledsoe et al., 2013). The onus is on the clergy to care for the parishioners in the fold, and in so doing, they are gratified when they are capable of assisting their members in every area of counsel as the needs arise, without having to introduce them to persons outside of the faith who may have methods contrary to those of Christ Wilder et al., 2020). The mutual satisfaction of the parishioner and the clergy constitutes a healthy relationship that could disallow a change in either party's symbiotic relationship (Carsello, 2022; Levinger, 1979).

Nature of Study

In this study, I have applied the research tradition of interpretative phenomenological analysis (IPA) that attempts to describe the individual's experiences of a phenomenon (see Smith & Fieldsend, 2021). This approach was used to seek answers to the RQs (see Rajasinghe, 2020). The qualitative method was selected to achieve the goal of this investigation, which can lead to an understanding of the clergy's experience in order to gain future insight in best proactive methodology to be practiced in other organizations. I interviewed 10 active Seventh-day Adventist Church pastors from the Atlantic Caribbean and Jamaica Unions. It was expected that these interviews would shed light into how parishioners' mental health issues are addressed in the Caribbean Seventh-Day Adventist Churches and understand pastors' training to address these consultations (see Rayburn, 2014). This methodology was selected given that little was known about how this group approached parishioners' mental health consultations (see Koeppe, 2014). IPA data analysis guidelines were followed in this study (see Smith et al., 2009; Rajasinghe, 2020).

Definitions

Clergy: This is a term used to define those persons who have pursued a career in religion or theology. It is a term that includes ministers of religion, usually called bishop, pastor, or reverend (O'Day, 2023; Payne, 2014). These pastors' function in a position of leadership in the community of faith in various denominations (McDonald, 2004).

Mental health: A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (World Health Organization, 2004, p.1).

Mental health professional: A professional person who by education and experience is professionally qualified to provide counseling interventions designed to facilitate individual achievement of human development goals and remediate mental, emotional, or behavioral disorders, and associated distresses which interfere with mental health and development (Segen's Medical Dictionary, 2011).

Parishioner: A person who goes to a particular local church and belongs to a parish (Segen's Medical Dictionary, 2011).

The Seventh-day Adventist Church: It is a church body that worships on Saturday instead of Sunday like other church bodies. The Sabbath, considered the seventh day, is supported by the 10 commandments of the Bible as found in Exodus 20 (General Conference of Seventh-Day Adventist, 2015).

Assumptions

In order to uphold the integrity of this study, there was careful selection of the particular strategies and methodology and many assumptions made for which there must be an account. In accounting for these assumptions, I first examined the main data source, the participants. I assumed that they would share their true experiences that were used as the main investigation in this phenomenon. I also assumed that my personal biases as the researcher in this study could surface, but my awareness and the strategies that are documented in this research would be applied to limit the influence of these biases. There may be impartiality in reporting the experiences of the participants as they answered the RQs. It is unlikely that the conveyed meaning was skewed. Thus, a clear understanding of the meaning of these experiences answered the RQs effectively.

Scope and Delimitations

The scope adopted in this study was a narrow one considering I used the experiences of select Caribbean clergy of the Seventh-Day Adventist Church that can adequately represent the whole group. This is because I studied the methodology of a specific denomination in order to assess their experiences of this phenomenon, which can yield favorable intelligence to aid others in addressing this situation in their sects. This denomination was chosen because of its global nature and size. The information garnered in this research can be beneficial to a large populace as it is intended that these data will be shared. The scope was limited to male participants, as the clergy of the Seventh-Day Adventist Church is predominantly male.

The experience of the clergy and their parishioners as it pertains to clergy assisting them in their consultation is usually explored in the United States and England; as such, the process is influenced by a different environment. The experience of clergy assisting parishioners was explored in the Caribbean and was viewed through the lens of the social exchange theory (see Blau, 1964). An understanding of how the Seventh-Day Adventist pastors in the Caribbean engaged with their mental health consultations may lead to an understanding of how to improve their responses to mental health consultations. The research was aimed at exploring the clergy's service offered to the parishioners and the clergy's perceived best practices.

The participating clergy (a) have worked as a pastor for at least the last 5 years, (b) have had consultations from members with mental health problems, and (c) were presently employed as a pastor. Participants were excluded if they did not fit the stipulated criteria. The participants had over 5 years of experience because when the pastor of a church is new to the ministry, participants tend to be reluctant to approach them for consultation as they may believe that they do not have the experience to address their situation. The clergy was currently employed because that ensured that the content given could be applied to a recent situation. Female clergy was excluded because they were not only difficult to find but many persons are skeptical of female clergy due to their own prejudice or their view of Jesus choosing only male disciples, among other reasons.

Limitations

One challenge encountered was the geographical area of the study, as the Caribbean conferences are made up of numerous countries, and traveling to the sites was both time consuming and costly and impossible in the COVID 19 era. Although face-to-face interviews would have been the ideal, I resorted to phone interviews, except for the pastors in my country, the Cayman Islands, where there was no travelling involved. Being a part of the Seventh-day Adventist Church may have elicited bias, but I used many strategies to reduce such personal biases. Examples of such strategies were peer reviews, committee feedback, participants reviewing the results, and coding comparison by multiple trained persons. Another potential limitation was social desirability. The participants may have been reluctant to discuss situations or cases in which they should have conferred or made a referral and did not.

Significance

The findings of this study can be useful in conversations of ministerial counseling. The clergy is the gateway to mental health care. The Seventh-day Adventist Church, the second largest church in the world with a membership of 21,912,161 served by 20,924 active pastors worldwide (SDA World Church Statistics, 2021), needs to be studied to see what strategies they apply when addressing the mental health issues of the parishioners they come in contact with on a daily basis.

The pastors of the Seventh-day Adventists church are trained in a seminary. A seminary is a college devoted to training persons for a theological education in preparation to be a pastor, priest, or rabbi. Thus, the aforementioned 145,024 seminaries

worldwide are a significant number of training facilities. In this research, I explored how participants described the preparation received at the seminary before becoming pastors. The institution that serves the ministers in this area in the Caribbean is Northern Caribbean University, which prepares their ministerial students for their role in pastoral care/counseling.

This study could help pastors become more aware of the complexities of addressing mental health consultations. Given that it is not known how much their ministerial training prepares them for this role, the findings of this study have the potential to shed light into the preparation pastors may need to address mental health consultations. The more trained and prepared they become, the better service they are likely to provide.

The results of this research may also benefit church members. With informed pastors, the members who bring their concerns to their pastors can benefit from the informed care. As a result, the general level of mental health in the church is likely to increase. The results of the study could raise awareness on stigmatization of mental health issues. The more open this topic is discussed in church settings, the more likely family members and society at large will not fear or suffer stigmatization or isolation. Additionally, the results of this study may encourage church members to rely less on pastors for mental health care and more on mental health professionals.

Results of this study could also have implications for the organizations from which the pastors operate. If pastors identify the need for further training, this could lead

to generating new policies. Thus, the findings may also affect decision making in the organization regarding the training of pastors.

Having pastors becoming more aware of their own practices and the nature of mental health could help normalize issues of mental health and allow for greater discussions, wider appreciation, and a higher degree of comfort around the subject. This is likely to increase community awareness and promote addressing mental health issues earlier, which could result in a healthier community.

Summary

This chapter contained background information on previous investigations that have addressed the need for future research to explore how the Seventh-day Adventist pastors of the Caribbean negotiate their mental health consultations (see Hirsch et al., 2014). I explained a general description of the phenomenon and the theoretical framework that supported the research. The key words were defined in order to prepare for a clearer understanding of the study. I also identified and discussed the scope and limitations along with the potential to bring about positive social change. Chapter 2 includes a more extensive exploration of the literature focusing on the origin of this phenomenon and its current status.

Chapter 2: Literature Review

Some people trust the clergy more than the medical and psychological professionals when dealing with their mental health issues. Many studies have shown that many parishioners prefer consulting the clergy when faced with mental health issues for several reasons (Crosby & Bossley, 2012; Derr, 2016; Kirk, 2018; Leavey et al., 2017). Though these reasons seem valid, several disadvantages may arise for both the parishioner and the clergy (Allen et al., 2010; Bilkins et al., 2016). Research has been conducted on various aspects of the clergy and their counseling habits, expectations, and limitations, but previous researchers have focused on research data collected in the United States and the United Kingdom (Vermaas et al., 2017). Little is known about clergy in the Caribbean countries and how they address their parishioners' mental health consultations.

The purpose of this phenomenological study was to understand how pastors from the Atlantic Caribbean and Jamaica Union of Seventh-day Adventist churches address their parishioners' mental health consultations. My second goal was to explore the type of training pastors received to respond to these consultations. In this chapter, I discuss the literature review strategy that I used to examine the existing literature, the theoretical framework I used to conceptualize the phenomenon of the study, and the specific literature on clergy consultations related to the topic of this study. This chapter concludes with a highlight of the gap in the literature and an affirmation of the need for this research.

Literature Search Strategy

To answer the RQs for this study, regarding the Seventh-day Adventist Caribbean pastors' experiences in addressing their parishioners' mental health consultations and describing the training received to serve, I used many search engines to fine relevant scholarly materials. The research engines used in this research included many sources and topics that support the research problem. I used the Walden University library to access the following databases: PsycARTICLES, PsycEXTRA, PyscINFO, PsycBOOKS, Academic Search Complete, Proquest Dissertations & Theses, and Google Scholar. I gathered various levels of publications relevant to the topic. I filtered the search to focus on the peer-reviewed articles that suggested future studies. This search also included textbooks and videos, as I attempted to explore the main authors that contributed to this conversation.

In my initial search, I used the following general key terms, such as *the clergy and mental health, mental health and faith, pastors and mental health,* and *spirituality and mental health* to identify quantifiable evidence on the subject. The key terms and phrases that I used for further search were *clergy/pastor and counseling, clergy/pastor and mental health, pastoral counseling in the Caribbean, pastoral knowledge of counseling, spirituality and counseling, clergy mental health referrals,* and *health seeking behaviors of parishioners/congregants.*

Theoretical Framework

I used social exchange theory as the theoretical framework of this study (see Blau, 1964; Cook et al., 2013; Wright, 2021). This theory purports that the parties in a

relationship are motivated by the benefits the relationship is expected to bring. Social exchange theory maintains that in any relationship, the exchange should maximize the benefits and minimize the cost. Therefore, people often weigh the potential benefits and the risks of a relationship, and they terminate it if the risks are more than the rewards. When people are satisfied with the outcome of the relationship, they are less likely to leave and seek other help (Wright, 2021). Social exchange theory was the most suitable theory for this research as it can be used to illuminate the helping relationship between the clergy and their parishioners. Clergy and parishioners hold an equitable valuable exchange. The clergy and parishioners keep a synergetic relationship that benefits both parties.

Several reasons have been stated for parishioners' preference to visit the clergy for their mental health consultations instead of mental health professionals. These reasons include cost or free service, cultural misunderstandings, stigmas, easy accesses, trusting the clergy, and suspicion of ethics on the part of the trained professional. Parishioners are helped with their consultations. They do not have to pay, they do not need insurance, they trust their pastors, and there is no stigma attached to seeing them (Campbell & Littleton, 2018; Chevalier et al., 2015; Crosby & Bossley, 2012; Payne, 2008, 2014).

The clergy benefits from taking care of the parishioners' consultations. Pastors have reported that their members are their social support (Hough et al., 2019; McDonald, 2004). It is the clergy's goal to care for the parishioners, and they feel gratified when they can assist their members in every area of counsel without having to introduce them to

persons outside of the faith. They believe that counselors outside of the faith may use methods contrary to their faith (Wilder et al., 2021).

The clergy is loved and supported by their congregation who treats and defends them like family (Elliason et al., 2013; Hough et al., 2019). Clergymen experience job satisfaction when their ministry thrives and is successful (Francis et al., 2017; Parker & Martin, 2011; Stewart-Sicking et al., 2011). The clergy often tries to help parishioners without referring them to outside sources.

Clergymen often seek advice and aid that are within the faith and refuse to risk losing the member (Hays & Lincoln, 2017; Payne, 2014; VanderWaal et al., 2012). When a member of the clergy refers a parishioner to an outside source, a subtle conflict can occur if mental health providers do not appreciate the important role that the patient's religion plays in the treatment process. Both clergy and mental health providers want the best for the patient, yet their history includes conflict with each other and mistrust on some topics (Heseltine-Carp & Hoskins, 2020; Josephson & Peteet, 2004). A collaborative effort between mental health providers and church members has tended to decrease this conflict in more recent years (Bonner et al., 2013; Smith et al., 2018).

Social exchange theory can be used to understand how and why both parties stay in a relationship. Costs and benefits are evaluated by members who keep a relationship. This theory applied to this study, as a member of the clergy is likely to guard and help their parishioners at all costs due to benefits associated with having parishioners. Hence, social exchange theory was an adequate theory to use to examine how pastors from the Seventh-day Adventist church address their parishioners' mental health consultations.

Literature Review Related to Key Concepts

In this literature review, I focused on the various topics that grounded this study. These topics included Seventh-day Adventist, clergy consultation, Caribbean church culture, reasons for choosing the clergy, global nature of clergy consultation, boundary issues, referral, and collaboration.

Seventh-day Adventist

The Seventh-day Adventist church was founded in 1863 and is a body of believers who worships on Saturday instead of Sunday. The Sabbath, considered the day of rest, is the seventh day of the week, and is supported by one of the 10 commandments of the Bible as found in Exodus 20:8. This text commands the believers to remember the Sabbath day to keep it holy and to do no work on that day. Part of the denomination's name, "Adventists," stems from the group's belief in the return of Jesus that is described in the Bible's last book, Revelation. An important part of this belief, found in Revelation 12: 6-12, is the three angels' message that warns of the importance of keeping God's commandments (Seventh-day Adventist, 2018). This denomination of the Christian faith believes that all the commandments should be kept, and the breaking of one commandment means an individual is guilty of breaking all 10. Therefore, Sabbath keeping is as important as not killing, lying, or committing adultery, which are three of the 10 commandments, and so is the Sabbath. The Seventh-day Adventist Church upholds 28 fundamental beliefs, which include the following topics: the holy scripture, the trinity, the Father, the Son, the Holy Spirit, creation, the nature of humanity, the great controversy, the life, death, and resurrection of Christ, the experience of salvation,

growing in Christ, the church, the remnant and its mission, unity in the body of Christ, baptism, the Lord's supper, spiritual gifts and ministries, the gift of prophecy, the law of God, the Sabbath, stewardship, Christian behavior, marriage and the family, death and resurrection, Christ's ministry in the heavenly sanctuary, the second coming of Christ, the millennium and the end of sin, and the new Earth (General Conference of Seventh-day Adventist, 2015; Twenty Eight Fundamental Beliefs, 2015).

A key doctrine relevant to this paper is the Seventh-day Adventist's early beginning that is found in Doctrine Number 17: spiritual gift and ministries. This doctrine is said to be based on one of the church's founding leaders, Ellen G. White. She manifested the gift of prophecy while she lived through the period 1827 to 1915. Ellen White is considered a prophetess of the Seventh-day Adventist church, and she documented her prophecies in hundreds of books that are used by the church today (Sanchez et al., 2016). This doctrine states that one of the gifts of the Holy Spirit is prophecy. This gift also identifies the true church and was manifested in Ellen G. White's ministry. Her writing is a continuing and authoritative source of truth, which provides comfort, guidance, instruction, and correction for the Seventh-day Adventist Church.

The Seventh-day Adventist Church also takes pride in its health message, which led to the development of the sanitariums in the United States in the 19th century. This church organization is an advocate for a vegetarian diet. All the facilities, food production, universities, high schools, hospitals, and other institutions operate on a vegetarian diet. Several studies have been done, through one of their prime universities,

Loma Lina, to demonstrate the benefits of the vegetarian diet and associating it with longer life and better health (Banta et al., 2018).

Seventh-day Adventist ministers are the spiritual leaders of one or more Seventh-Day Adventist Church or churches. They are trained in a Seventh-day Adventist-owned tertiary institution, a seminary, to at least a bachelor's degree level. In their role as head of the church, they protect both their members and the 28 fundamental beliefs with great passion. Parishioners' consultations could range from any topic that a client could possibly take to a mental health counselor, with the exception of a few. In a recent study, church members of various congregations were asked what they felt comfortable talking about to their pastors (Harris, 2018; Jones et al., 2012). Most of them felt comfortable talking about many issues but reported their discomfort in talking about sex, drugs, and domestic violence, as these were very sensitive to speak to their spiritual leaders about. Parishioners' consultations are driven not only by cost but the branding that comes with seeking mental health care is being avoided (Brown & McCreary, 2014; Chevalier et al., 2015; Harris & Wong, 2018; Jones et al., 2012).

Clergy Consultation Overview

History

In the ancient days, healthcare was known to be spiritual care as it was the Egyptian temples that provided care for the ailing (Reed, 1997; Villas Boas, 2020). In fact, the first hospitals were built by religious organizations and staffed by religious personnel. During the Middle Ages and through the French Revolution, clergies were often used as physicians, and it was the religious organizations that licensed health care

personnel (Assman et al., 2018; Koenig et al., 2012). This spiritual understanding of illness lasted until the period of enlightenment when psychology began to develop, thus creating a separation between the church and the mental health institutions (Fulford & Jackson, 1997; Fulford, 2018).

The separation of the mental hospital from the church to the secular authorities led to abuse of patients. This inhumane treatment even resulted in the death of many patients (Gamwell & Tomes, 1995). The death of a famous Quaker, and the abuse in general, initiated a new kind of treatment that was introduced by a Quaker, William Tuke, as "moral treatment." The Quakers eventually set up their own asylum in England and then brought it to the United States (Taubes, 1998). This separation was further fueled in the 17th century when the scientific giant Wilhelm Wundt helped to formalize psychology up to the 18th century (Benjamin, 2023). Wundt built his psychology on the mental science relating it to natural science and to philosophy. Wundt's basic ideas evolved into a bio-cultural understanding of human development (Wong, 2009).

The separation of the mental hospital from the church was further encouraged by Sigmund Freud. Freud promoted this separation in a series of writings during the early 1900, which includes topics such as religious act and obsessive practices, psychoanalysis and religion, future of an illusion, and Moses and monotheism (Assmann et al., 20) These writings' influence on psychotherapy led to the division but more importantly, they led to the review of the religious content in the Diagnostic and Statistical Manual of Mental Disorder . This divorce of religion and mental health eventually led to skepticism in the profession of psychiatry and psychology. In more

recent times, religion is being reintroduced into the conversation and continues to play a powerful part in psychotherapy (Barnett & Johnson, 2011). In fact, with the prominence of psychology and its varied professional arms, mental health professionals naturally operate in the cities where most people converge. On the other hand, in rural areas, with the absence of professionals who operate in the city, which is more populated, the clergy became the gatekeeper of mental health in those rural areas (Payne & Hayes, 2016).

Statistics on Clergy Consultation

The clergy is called the gatekeeper of mental health, not only because they can be accessed where professionals are not present but because they are the first responders due to the fact that churches are strategically located everywhere (Heseltine-Carp & Hoskins, 2020; Milstein et al., 2008). It is even suggested that clergy, being familiar with their members, may be able to recognize emotional change as opposed to mental health professionals who may be strangers or mere acquaintances (Hays & Lincoln, 2017; Young et al., 2003). Many individuals seek help from the clergy, and this practice has been prevalent throughout the centuries. Researchers have reported that 25 to 40 % of Americans have sought mental health services of the clergy (Hays & Lincoln, 2017; Taylor et al, 2011; Wang et al., 2003; Woodward et al., 2010). In fact, a group of researchers reviewed studies over a 20-year period on the topic psychology and religion and discovered that 44 studies were done on these areas (Wood et al., 2011). In a more direct way, it was noted that 40% of church attendants did mental health consultations with the church (Wood et al., 2011). The clergy themselves reported that they spent at

least 15% of their time doing counseling, and this percentage was even higher in those rural areas where there were fewer professionals (Chan et al., 2016).

Many of the problems that the clergy respond to include grief and bereavement, medical concerns, marital and family conflicts, life stressors, and psychiatric disorders (Chatters et al., 2017; Mattis et al., 2007; Wang et al., 2003; Young et al., 2003). The clergy is more likely to be consulted for mood and anxiety disorders than the psychiatrist (Iheanacho et al., 2018; Wang et al., 2003). In fact, in a study with 39 pastors, they reported counseling their members concerning many and varied topics. Over 91% of those pastors reported discussing marriage and family problems, 87.5% spiritual problems, 79.2% bereavement, and 78.8% job problems, among other topics (Brown & McCreary, 2014). The clergy is approached by their parishioners because the church provides psychosocial resources and culture similarity (Dalencour et al., 2017; Young et al., 2003).

Caribbean Church Culture

The church culture can be defined as the background of the people who attend and this include their attitude, beliefs, and customs (Thompson, 2008). The Caribbean church has a culture in which the clergy is consulted for various kinds of situation; thus, the changing of hats for the clergy as they serve in multiple roles. Church activities range from praying, singing, listening to positive messages, sermons, fellowship, faith experiences and praising, and are very therapeutic to members (Cook & Wiley, 2014 Hope et al., 2019). These activities also bolster the strength of the varied coping mechanisms of the members. It is due to this extensive scope of social support of the

Caribbean church that many individuals prefer this informal source to manage their mental health issues (Dupree et al., 2005; Hope et al., 2019; Murry et al., 2011). Black churches also have an established culture of organizing education, health services, and social activities for both members and the communities. Many of their programs include youth programs, financial initiatives, and programs for the elderly, to name a few. These initiatives reflect the worldview of inclusion and collectivity of the black church as it seeks to influence the wider society (Hope et al., 2019: Taylor et al., 2011).

The culture of the Seventh-day Adventist Church is a very formal and sophisticated one in which the minister is required have at least a bachelor's degree in theology or religion, but the entry level required in most conferences is a master's degree. They believe that the pastors should be equipped with a higher degree in order to adequately relate to the members who are exceptionally educated in the 21st century. Although they are educated, the literature suggests that they are not equipped to address mental health issues except in cases where they are specifically trained in the area of mental health (Bledsoe and Adams, 2011: Heseltine-Carp & Hoskins, 2020). Despite this, the members of the congregation seem satisfied with consulting their pastors for many of their mental health issues (Neely-Fairbanks et al., 2018: Woodward et al., 2008).

Reasons for Choosing Clergy

Access to Churches

A church can be found in almost every major community in the Caribbean and one could say globally. Statistics show that African Americans/Afro-Caribbean people are very religious (Walker et al., 2012). The statistics in the Caribbean are limited but

may be similar to African Americans in the United States of America. The 2010 Gallup Poll indicates that 78% of Americans report that they are associated with the Christian faith (Walker et al., 2012). Ten years later, in March 2021, there has been a decline as 47% of Americans identified as Christian in the same Gallup poll (Jones, 2021). In the Newport (2010) survey, it was found that 56% of Americans specified the importance of religion in their lives and another 25% indicated that it is fairly important to them. In April 2021, the survey found that 48% Americans said that religion was very important in their lives (Jones, 2021). Caribbean people practice faith, and the churches are accessible to them. Research has suggested that 59% of clergy has counseled persons with mental health issues (Chatter et al., 2017; Hall & Gjesfield, 2013; Smietana, 2014). A survey done with over 200 clergy from over 50 denominations shows that over 50% of them encounter mental health and substance abuse issues more frequently than monthly (Jordon, 2020; VanderWaal et al., 2012).

Gatekeeper

The churches are accessible because they are strategically located in the major communities, thus the label "gateway or gatekeeper" is given to the clergy and rightly so (Heseltine-Carp & Hoskins, 2020; Payne, 2014; VanderWaal et al., 2012;). Being a gatekeeper is a major responsibility and therefore the clergy should be equipped with the knowledge of recognizing the mental health illnesses and making referrals (VanderWaal et al., 2012). In one study, the clergy reported that they spent 15% of their work time counseling with their members (ONS, 2016; Wood et al., 2011;). The question is, how the help-seeker view the clergy as a source of advice. A social survey examined the

clergy's role as frontline mental health worker and found that regular parishioners are more likely to approve of the role. Members fifty-five and over are more likely to endorse the role and the clergy are seek their help for serious mental illnesses and physical problems. (Nguyen et al., 2020).

Stigma

The stigma associated with mental health is another reason member consult with the clergy instead of mental health professionals (Brown & McCreary, 2014; Chevalier et al., 2015; Jones et al., 2012; Stull et al., 2020). Stigma is defined as discrimination and hate and has been a barrier to seeking professional mental health care (Bracke et al., 2017). This leaves the mental health patient feeling diminished, devalued and fearful due to the negative attitude, and with this they are deterred from seeking the help they need (Gluck, 2015). Interestingly, research shows that the clergy helps to stigmatize the persons with mental health illnesses (James et al., 2014). This stigmatization occurs in several forms including (a) The use of prayer instead of medication for depressed members, (b) performing of exorcism, and (c) competing with traditional healers (Peteet, 2019). In a literature review of 36 studies on public stigma of mental illness, 23 studies looked at stigmatization towards mental health consultants from professionals, 15 studies looked at the stigma as belief about the person's criminality and harmfulness. The other ten saw stigmatization as social distancing (Parcesepe et al., 2012).

According to researchers, stigmas are commonly held stereotypes about persons with mental health illnesses. These stereotypes include how dangerous they are, that they are incompetent and they cannot live normal lives, and it is suggested that these persons

are to be blamed for their condition. People with mental health illness have a double challenge. Firstly, it interferes with the person's social roles and self-sufficiency in life and secondly, society's reaction to them through discrimination which results in the stigma. The greatest factor which poses a worse challenge is the self-stigma these persons develop as a result of the first two challenges (Brouwers, 2020; Oexle, 2017). This stigma robs them of their self-esteem due to the internalizing of the stigma that society throws at them. It is because of this grave problem that mental health patients and their family, prefer to disguise their care by seeking help from the clergy (Hays, 2020; Livingston & Boyd, 2010).

Free or Low Cost

Another reason for choosing the clergy is that the service is either free or at a low cost (Kawaii-Bogue et al., 2017; Pargament & Lomax, 2013; Payne, 2008, 2014; Thomas, 2012). Regular users of clergy for mental health consultations are the African American/Afro Caribbean, more than any other group. The African American consults with the clergy for several reasons. The earning power of many African American/Afro Caribbean is minimal; therefore, when spending, they usually have to think twice about substitution (Crosby & Bossley, 2012; Kawaii-Bogue et al., 2017). If they believe that they can get the same service from someone they love and trust, as against the cost of a professional stranger, then they will choose with their economic needs in mind. Many are without health insurance also and would not be able to afford mental health treatment costs and therefore choose the best alternative, the clergy (Kawaii-Bogue et al., 2017).

Trust.

This is a major reason that parishioners make the clergy their consultant in mental health. African Americans tend to perceive psychological consultations negatively and that is one of the big fears of speaking to mental health professionals (Crosby & Bossley, 2012; Gonzalez et al, 2011; Whaley, 2001). The clergy themselves do not believe that the mental health providers value their spiritual input and therefore do not reciprocate referrals. They also do not trust the professionals as beneficial in helping their members in keeping the faith; this implies that the methodology of the professional may drive the persons away from the church (Hays et al, 2017; Sullivan et al, 2012; Wright, 2021).

Cultural Understanding

The mistrust of certified mental health professionals is another thing that the Afro-Caribbean members has to grapple with as well. Many black people do not understand white people because they do not intermingle with them for various reasons including a lack of opportunity. They therefore do not understand much of their communication and gestures and are not sure if it means the same as in their culture. They therefore do not believe that people of other cultures understand them. In fact, black people believe that if they choose to enter therapy, there is a greater chance that the therapist will be Caucasian and would not understand their experiences. They would rather see someone of their own ethnicity than to even try interacting with someone who, in their mind, would not be able to identify with their experiences (Campbell, 2021; Sanders Thompson et al., 2004).

Global Nature of Clergy Counseling

The consultations of the clergy are not just a phenomenon of the Caribbean or United States where Caribbean people migrate, it seems to be a global experience of the African Christians as they converge in the United Kingdom (UK) (Leavey et al., 2017). Like the researchers of the US, the British researchers spoke of the disappearance of the white British born members that are vanishing from the church and are subsequently replaced by both Africans and Afro-Caribbean people. With this exodus, the church leaders are now predominantly African or of African descendants. There, the multi-cultural mix is described in the churches as a spiritual marketplace (Leavey et al, 2017). Here, the culture and immigration are analyzed to determine their effect on the phenomenon.

Immigration

Caribbean people have always migrated to countries with a stronger economy in search of a better life. The two main countries to which they usually go is the US and the UK. In the US, the Caribbean immigrant population grew from 924,693 to 1,542,895 by the year 2000, displaying a 67% increase (Logan & Diane, 2003). By the year 2010, there was an increase of 26% bringing the population to 3.7 million and by 2017, another 18% growth occurred showing an increase of 4.4 million Caribbean immigrants to the US (Zong & Batalova, 2019). This is a significant number of people and enough to make major impact on the cultural diversity of the country.

The UK had its share of impact through immigration with an influx of Caribbean immigrants from as early as 1948 after World War II with 492 Jamaicans taking up

residence there. They were invited to join the population in order to rebuild the economy (Philo, 2018). This influx of people became known as the Windrush Immigrants and was a historic addition to Britain's population. It is ironic that in 2019, after these many years, the British government has made laws negatively affecting this population after having multiplied into many generations. The dictates of these laws require a deportation of the offspring of the Windrush Immigrants as illegal settlers (Mead, 2009, Philo, 2018).

Culture

Few researchers have looked at the culture of pastoral consultation in the Caribbean; however, there are many that describe the behavior of the immigrants to both the US and the UK. It is believed that globalization has altered the beliefs and behavior of immigrants and has also influenced the belief and behavior of others they have joined (Leavey et al, 2017). A number of studies have alluded to the view that the help which the immigrants seek differ from that of the natives because of their immigrant experience (Abe-Kim et al., 2007; Mental health report, 1999). Yet many of the research are looking at the Caribbean immigrants and their help-seeking of the clergy in the countries in which they migrated.

Clergy Training

In general, the clergy is trained in Theology or Religion with one course called Pastoral Counseling. The degree of training is dependent on the denomination as some churches believe that the pastor should not be trained but should be solely dependent on the influence of the Spirit. But as the gatekeeper of mental health or first responder, the clergy ought to be prepared to address mental health consultations (Heseltine-Carp &

Hoskins, 2020; Payne, 2014; Payne, et al., 2016; Smietana, 2014). The standard set by the American Association of Pastoral Counselors (AAPC) for clergy counseling is a bachelor's degree from an accredited university or college or seminary and a specialized masters or doctoral degree in the mental health field (AAPC, 2012; Payne, 2014; Roney, 2020). There is a strong preference for personnel that holds this kind of qualification due to the knowledge of the integrative mix of both religion and mental health. It is believed that this combination of qualification is the best option for pastoral counseling (AAPC, 2012; Farshadnia, 2009; Roney, 2020). The problem is that some clergy do not believe that they should be trained whether for pastoral care or mental health counseling.

Denominational Differences

The Seventh-day Adventist clergy, on the other hand, believe that the more educated you are, the more competent you are to deal with the various levels at which the congregants are operating. The Inter-American Division, of which the Caribbean pastors are a part, boasts thirteen (13) seminaries from which the Caribbean pastors can gain their basic degree, the BA Religion (Bachelor of Arts Religion). Presently, the standard for the Seventh-day Adventist clergy is a master's degree. The required entry level for the Seventh-day Adventist pastor to be employed is a bachelor's degree, but the preference presently is that each pastor employed or entering the field, seeks to update to an acquisition of a master's degree. In spite of such a high level of education required in the ministry for those denominations who believe the clergy should be educated, studies show that they are not qualified to counsel their congregants except on spiritual and general matters (Brown & McCreary, 2014; Vermaas, 2017).

Competence

Competence is described as the performing of one's professional role within the standards of practice, as described by the APA and involves all disciplines including psychiatry, counseling, social work, and psychology. Each discipline has its own specific code and shows similarity in what is covered. The code requires that one has professional knowledge to recognize the limitation and expertise. A lack of expertise in the area in which they are performing can hurt the client and the therapist alike (American Counselors Association, 2014). Evidence suggests that a large number of clergy lack formal training and do not feel they have the competence to deal with mental health issues (Payne, 2014; Poole, 2017; Smietana, 2014). Other researchers found that the clergy needs to be more aware than even those in the nonspiritual professional environment; understanding their limitations and having knowledge of the standard for professional practice in the counseling relationship (Eliason et al., 2013; Guo et al., 2011; Poole, 2017). With this standard of expected competence, the question of what the clergy believes about their own capabilities has been raised.

Clergy's Belief of their Competence

In the clergy's effort to help all their members, they sometimes recognize their lack of competence. African American clergy are the most used for parishioner consultation; therefore, they usually have a working list of resources for referral (Cook & Wiley, 2014). In fact, referrals and collaboration is the ideal way to improve the relationship between the clergy and the mental health professionals and secure the needed help for the parishioners (VanderWaal, et al., 2012). Training and education are identified

as the key requirements for competence in future practice (Payne, 2014). Evidence has suggested that a large number of clergy lack formal training and do not feel they are equipped to deal with mental health issues (Payne, 2014; Poole, 2017; Smietana, 2014).

Boundary Issues

In spite of the concern about qualification and competence among some pastors, many seem to feel obligated to assist when parishioners make consultations. The problem with that is the issue of boundary crossing which arises with various areas of violations. The areas of boundary crossing violation explored in this paper are dual relationship, sexuality, confidentiality, counseling competency, self-protection, harm or no harm (APA, 2017)

Multiple Roles

A pastor endeavors to have a good relationship with all members and guests of his congregation. He is all things to his congregation, wearing many different hats and fitting in different situations. Being their pastor and at various times fitting into other roles brings about a multiple relationship when he wears the hat of counselor. According to the APA, multiple relationships or dual relationship occurs when the behavioral professional has two or more roles with the counselee or is in a relationship with someone closely related to or associated with the counselee or even promised to be in other relations with the counselee or someone related to the counselee (APA, 2017).

Some of the common roles that the clergy of the Caribbean Seventh-day Adventist Church often take on in ministry are pastor/shepherd, church leader, friend, relative, spiritual advisor, teacher, confidante, family support, advocate, coworker,

neighbor, power position and much more as the necessity arises (Parent, 2006). Many researchers wrote about the issue of boundary crossing and its effect on the counseling relation which especially affects the clergy due to their unique role (Eliason et al., 2013; Friedman, 2020; Guo et al., 2011). Others believe that dual relationship will always occur with the clergy and that is something they have to be aware of and declare in order to protect both self and the counselee. Such boundary intrusion due to the many roles in the pastor's portfolio not only stresses the pastor but can confuse and harm counselees due to the pastor's lack of objectivity brought on by the dual relationship (Bledsoe et al., 2013; Friedman, 2020; Justice & Garland, 2010).

Sexuality

Another boundary crossing is sexuality. When the pastor is not trained in the ethics of counseling, coupled with the dynamics of poor accountability and narcissistic thinking and other characteristics, crossing sexual boundary is possible (Perry & Pierre, 2021). The counseling relationship can easily foster such relationship if one is unaware of the warning signs of such a direction. There is also the unequal power of leaders and especially those with the "power of moral persuasion" that is at work in the pastor versus parishioner relationship (Shupe, 2007). One researcher refers to the charisma of the clergy's office as the title which have their parishioners respecting them with godly fear (Poling, 2005). According to Capps (1993) religious leaders hold three kinds of power that could prove dangerous if not managed well. They are the power of freedom from surveillance, the power of access, and the power of intimate knowledge about their parishioners. This is a kind of power that the professional mental health personnel do not

have as they are not allowed access to the client outside of the office visits and they also have more accountability due to supervision. All these foster boundary issues and leave the clergy vulnerable to sexual misconduct (Letuka, 2020). According to Garland and Argueta (2010), whenever people are given power, they will find the opportunity to abuse it and many actually abuse it. The clergy, as a trusted leader with not much supervision, has the opportunity to abuse its parishioners by crossing sexual boundary through the avenue of counseling (Perry & Perry, 2021).

Confidentiality

This is another area in which the clergy can easily yet unintentionally cross the boundary. Sometimes it is just the perception of the counselee that the pastor has broken confidentiality when she hears her case repeated by others. It is not necessarily the pastor, but she who related the pains of her heart and sometimes forgets that others were informed; thus, resulting in an unsupported accusation of the pastor. Another reason the pastor is usually suspected of breaking confidentiality is that during his sermons, he relates stories and examples that may seem similar to the counselees' cases which can easily be interpreted as their story (Rankin, 2019).

Confidentiality is one of the most common boundary violations of both the clergy and the professional counselor as information being divulged either in illustrations, to spouse, or to colleagues without the permission of the counselee. Even with the spike of sexual abuse crimes in the Catholic Church, the clergy of many denominations are still valued and esteemed as authority figures of the church (Courtois & Steinberg, 2021)

In counseling, the client has a right to confidentiality. Many clergies who are not trained in counseling are not aware of the limits of confidentiality. An example of this was in the Cayman Islands where a minister was imprisoned because she did not have the knowledge that there were limits to confidentiality (Dobrin, 2002; Sanders, 2013). A young man who was involved in a gun crime confided in her and when the court tried to get the information from her, she insisted that she could not divulge the information (Morgan, 2010). The actions of an untrained clergy can result in legal issues for a lack of knowledge in the counseling arena as this pastor, like many others, acted upon her need to protect the rights of the client, but was very oblivious to the limits of the bounds of confidentiality. The clergy and the professional counselor have the client's best interest at heart and therefore the maintenance of confidentiality depends on the subject discussed, the ethics of the counselor and the laws of the governing body (Griffiths & Young, 2004; Rankin, 2019).

Competency

The accepted standard of counseling is that one operates in the boundaries of their competence based on their training, education, and supervised experience (Tien et al., 2012). Many of our pastors only training in counseling is one course; Pastoral Counseling and those who are not formally trained have no knowledge to work with in the area of counseling (Eliason et al., 2013; Vermaas et al., 2017). The clergy is called first responder by several authors because churches are located strategically in various districts and pastors do spiritual counseling. Their congregants trust them enough to consult them for advice and counseling (Hall & Gjesfield, 2013; Heseline-Carp &

Hoskin, 2020; VanderWall et al., 2012). It is the pastor's duty to decide whether it is spiritual counseling that is needed or otherwise. In light of this, the clergy should be equipped with knowledge of resource personnel which will enable them to appropriately refer their counselees when they are consulted for guidance in areas in which they have no competence (Nichols, 2023; Payne, 2014; Smietana, 2014). Therefore, if the clergy is trained in counseling, they are held accountable by the Code of Ethic of the Counseling Association and if they are not trained they do not have a clear understanding of the risk of not setting boundaries but are aware of the ethics counseling and need to be accountable to their church organizations (Wangaru, 2019).

Referral

Knowledge for Referral

Many pastors are not formally trained pastors depending on the denomination, as established before. Those who are formally trained have had very little studies focused directly on counseling except for those who do extra studies to qualify as counselors. This statement brings into question the untrained pastor's ability to recognize a case he cannot really address. Will he be able to recognize a depressed person, a suicidal person, or someone showing signs of Schizophrenia instead of believing that the person is possessed with demons (VanderWaal et al., 2012). This knowledge and belief about mental health disorders and being able to recognize them is termed mental health literacy (Jorn, 2012; Vermaas, 2017). These writers advocate that this mental health literacy is necessary to help with diagnosis and the aftermath.

Payne (2014) did an extensive study on 204 pastors in the California area from 26 denominations with the aim of discussing the statement, “The Pastor is the best person to treat depression.” The study explored how both secularly educated or theologically educated pastors view intervening with depressed individuals. The level of the pastors’ education did not change their belief that the pastor was the best person to treat depression. Neither did it change their view about referral to mental health professionals. These findings indicated the need to pay extra attention to the initial training of the clergy as the reality is that they are the first responders in many mental health cases (Payne, 2014; Heseltine-Carp & Hoskins, 2020).

In another study done by VanderWaal et al. (2012), over 200 clergy from over 50 denominations were consulted to explore their willingness to collaborate and refer their members to professional mental health services. Among this group, 86% believed that they could recognize persons with mental health challenges. There were 37% that believed that persons with serious mental health challenges could be possessed by demons. Seven percent of pastors believed that persons with mental health challenges are often imagining their problems and 5% would actually encourage a church member to stop taking medication for a mental health challenge in favor of seeking spiritual healing. Only three percent (3%) of these pastors had not referred their members to mental health services for fear of broken confidentiality. The majority of the pastors were more positive about these issues which proves more hopeful that referrals would be made (VanderWaal et al., 2012). Many pastors’ views have not changed much in recent years (Harris, 2018; Leavy et al., 2017).

Researchers are aware of the lack of knowledge of some pastors or difference in beliefs among pastors of various congregations, thus, fostering the use of instruments that test one's mental health literacy (MHL) (Jorm et al (1997). The older method of measurement of one's MHL was the vignette case study, more recently, the Mental Health Literacy Scale (MHLS; O'Connor & Casey, 2015). The MHLS is a computer-scale-based questionnaire with scoring from 35 to 160. It measures the person's or group's ability to recognize disorder, know where to find the resources, recognize risk and cause, understand help seeking, and exhibit help seeking behaviors (O'Connor & Casey, 2015). When this MHLS was applied to clergy to test their MHL, the results revealed that the clergy of all denominations, age, educational level, and geographical regions needed more training and collaboration, which would also likely increase mental health referrals (Vermaas et al, 2017).

Collaboration

Without collaboration and with mistrust between the clergy and the mental health professionals, there will be no referrals from the clergy to needed therapy or psychiatric medication management (Heseltine-Carp, 2020). It is established that the clergy is an informal gateway to mental health needs not only to the problems of parishioners but also to prevention of their mental health issues (Brown & McCreary, 2014; Heseltine-Carp & Hoskins, 2020; Payne & Hays, 2016; VanderWaal et al., 2012). As globally recognized first responders, the clergy need to be taken seriously and attention should be paid to their readiness to continue and ensure their knowledge of resources for referrals. Some researchers indicate that clergy would do well with mental health literacy, thus being

better able to identify serious mental health problems (Aten et al., 2017; Payne, 2014; Vermaas et al., 2017). Others believe that referral will increase not just with training and collaboration but with improved inter-professional alliance (Sullivan et al., 2014; Thomas, 2012; Vermaas et al, 2017).

Not all clergy are unwilling to refer their mental health cases, as indicated by a survey done with over 200 clergy from over 50 denominations (VanderWaal, 2012). In fact, almost 90% indicated their willingness to allow a counselor into their church to do seminars and lead support groups. Over 85% of the 200-clergy surveyed thought it was important to their referral that the mental health professional be a Christian: denomination and ethnicity was also of importance to them (VanderWaal, 2012). With this kind of collaboration and synergy, the clergy would have the knowledge of resources necessary for referral (Allen et al., 2010; Vermaas et al., 2017). They would be able to get the kind of help necessary to differentiate who needs spiritual help, medical help, and who needs mental health help (VanderWaal et al., 2012).

Continuing Education

Another thing that the clergy may benefit from is a system where compulsory continuing education is required for their profession. Such a program might be a way of adding some of the information and necessary training that ensures that first responders such as the clergy equip themselves with the necessary information to be effective (Kehoe & Dell, 2021).

The pastors of the Seventh-day Adventist churches in the Caribbean do not have a formal policy on continuing studies, but they do have conferences that prepare their

pastors with more efficient ways of alleviating issues as they arise. Many of the conferences in the Seventh-day Adventist Church also have an entry level for ministers with master's degree. This education level gives the additional thrust needed to more adequately prepare the clergy to help with the consultations of their parishioners.

Summary and Conclusion

Research on Seventh-day Adventist Church clergy and how they address their parishioners' mental health consultations in the Caribbean is an interesting phenomenon. It is believed that some people trust the clergy more than the medical and psychological professionals when dealing with mental health issues. It is unknown whether the pastors have the competency for such demands and are able to recognize serious mental health issues and find the resources that can help.

The pastors of the Seventh-day Adventist Church are well respected and trusted by their congregation and community members. Having heard them from the pulpit each week, they believe the man of God can take care of any problem they have, except for a few topics that they may find discomfort in presenting due to their nature of these issues. Clergy consultation is of a global nature and they are seen as gatekeepers of mental health by many researchers. Therefore, the prevalence of the use of the clergy is mainly due to the stigma attached to mental health and is seen as reason to avoid the mental health professional and embrace the clergy. Other reasons cited are free or low cost, lack of insurance, trust, access to churches and cultural misunderstandings.

The issue of clergy training arises when one looks at their competence to deal with serious mental health issues and being able to recognize them and even to make

referrals. This becomes an even bigger issue when the research shows that some pastors do not even have pastoral training due to the belief of their religious denomination. There is also not much apparent collaboration between the clergy and the mental health professionals as seen in their referral history or the lack thereof. Hence, research on clergy and how they handle their parishioners' mental health consultations in the Caribbean is limited to non-existing. An understanding of these experiences may provide meaningful insight on the quality of such practices. Results of this study will have the potential to bring about the interest to rectify, empower, or enhance such practices.

In the chapter that follows, the design choice and its rationale will be described. The sampling strategy and population will be introduced. The data collection method will also be described as the phenomenon unfolds through the stories of this selected population, thus answering the posed RQs. The issues of trustworthiness show strategies encompassing credibility, transferability, dependability, confirmability and coder's reliability. Finally, the ethical strategies in dealing with both the participants and the data were considered in upholding the integrity of the study.

Chapter 3: Research Method

The purpose of this phenomenological study was to understand how pastors from the Seventh-day Adventist Church address their parishioners' mental health consultations and to explore pastors' training to address these consultations. This chapter includes a discussion of the research design that I used, the rationale for selecting it, and why I selected it. This chapter also includes a discussion of the strategies used to select participants for this study, data collection procedures, data analysis, the strategies I selected to ensure the trustworthiness of the study, and the ethical considerations.

Research Design and Rationale

The central RQs in this phenomenological study were as follows:

RQ1: What are the Seventh-day Adventist Caribbean pastors' experiences in addressing their parishioners' mental health consultations?

RQ2: How do Seventh-day Adventist Caribbean Pastors describe the training received to serve their parishioners' mental health consultations?

The purpose of this study was to explore how Seventh-day Adventist Caribbean pastors address their parishioners' mental health concerns and describe the training they received to address these concerns. This is a global phenomenon, especially among the Afro-Caribbean, African American, and colored people worldwide (Eliason et al., 2013; Hibbert, 2023). In this research, I focused on Seventh-day Adventist pastors due to the fast growth of this church in the Caribbean and the influence of the clergy on such a large group of the population (General Conference of Seventh-day Adventists, 2015; Heck et al., 2018).

There has not been a great deal of research conducted in the Caribbean about parishioners' mental health consultations with clergy, but studies have been conducted on this topic in other countries, such as the United States and the United Kingdom (Abe-Kim et al., 2007; Campbell & Littleton, 2018; Derr, 2016). In these countries, there has been research conducted on the usage of pastoral consultations by Caribbean immigrants (Leavy et al., 2017). The clergy is sought after in the Caribbean to assist with many issues, including mental health issues, and is the first point of contact for many with mental health issues (Brown & McCreary, 2014; Payne & Hays, 2016; VanderWaal et al., 2012). In my study, I examined how such consultations are dealt with and whether the clergy of the Seventh-day Adventist churches in the Caribbean feel prepared to address them.

Qualitative Research Approach

I used a qualitative approach for this study. Creswell (2017) described the qualitative approach as one that begins with assumptions, followed by the use of interpretive or theoretical frameworks that are used to address meanings that individuals give to these problems. Researchers use the qualitative method to understand the specific experiences of the participants in their study (Abu-Alhaija, 2019; Creswell, 2013). In qualitative research, individuals or groups share their stories with the researcher who interprets them (Maxwell, 2012).

I used the qualitative method to understand the ways in which Seventh-day Adventist Caribbean pastors address their parishioners' mental health issues and how the training they received prepared them for it. A qualitative approach was a good fit for this

research problem as the experiences of the participants were important to answering the RQs. Therefore, I used interviews to obtain the data in order to capture the experience of this phenomenon. There is not much known about the Seventh-day Adventist Caribbean pastors' experiences with their parishioners' mental health consultations. Research on the clergy and mental health topics have been conducted in other countries or with other populations (e.g., Avent et al., 2015; Campbell, 2021; Exline, 2021; Smith et al. 2018). However, it is not known whether results of the research conducted in other countries or with other populations could be transferred or generalized to Caribbean pastors. Therefore, gathering Caribbean pastors' in-depth narrative with first person account can significantly add to the research literature.

Phenomenology

The appropriate research tradition to answer the stated RQs in this study was phenomenology. The general approach of phenomenology aims to identify a phenomenon and reach a thorough understanding of it by developing an overall essence of the experience from the participant's perspective (Abu-Alhaija, 2019; Creswell, 2013). I considered a number of approaches for this study, including the narrative approach, grounded theory, and ethnography. The narrative approach is appropriate for reaching a deep understanding of the participant's life and their experiences, or it can take the form of a biographical lens, in which the researcher focuses on capturing the life story of a single participant or the exploration of turning points in people's lives (Abu-Alhaija, 2019; Creswell, 2013). I chose not to use this method as this was not the focus of my study. Grounded theory is used to examine participants' voices and develop a theory or

conceptual framework (Abu-Alhaija, 2019; Creswell, 2013). This approach was not appropriate because my goal was not to generate a theory or conceptual framework. An ethnographic design is most appropriate in examining shared culture, including language and behaviors in specific and natural settings (Abu-Alhaija, 2019; Creswell, 2013). Ethnographic researchers interpret and analyze cultures, subcultures, or specific social groups (Abu-Alhaija, 2019; Creswell, 2013). It was not my goal to understand shared cultural beliefs; therefore, this approach was not appropriate. In conclusion, phenomenology was the most appropriate framework for the design of my study.

IPA

Within the phenomenological umbrella, a wide array of approaches exists (Paley, 2017). Within the various approaches, I selected IPA (see Smith et al., 2009) for this study. I chose IPA due to its increasing and wide use in psychology and psychotherapy research (see McLeod et al., 2021; Sallay, 2019). IPA shows a well-developed methodological guidance (Tuffour, 2017), which helps in clearly delineating the steps in this study. As a methodology, IPA uses a version of phenomenology concerned with how human beings understand and interpret their experience and make sense of the world, proposes RQs focusing on personal experience, and mainly uses interviews to gather first-person accounts of the phenomenon under study (Abu-Alhaija, 2019; Smith & Fieldsend, 2021; Smith et al., 2009). IPA is a participant-oriented approach that honors the experience of each participant.

IPA is concerned with how individuals perceive events, opposed to describing the phenomenon using a preexisting assumption. Understanding the participants' view of a

phenomenon is a first step in IPA; second, through an interpretative process, the researcher tries to decode that meaning to make sense of the participants' unique perspectives. Discerning participants' deep meaning is in line with gaining understanding of Caribbean pastors' experiences in addressing their parishioners' mental health consultations and exploring how adequate they perceive their training to address these consultations.

Role of the Researcher

In qualitative research, the researcher is the instrument for collecting and analyzing data (Maxwell, 2012). The researcher is both an observer and interviewer and can be conflicted in their relationship with participants (Kang & Hwang, 2021; Vitus, 2008). The rapport between the researcher and the participants is vital for the success of such an investigation and the validity of the data to be presented. This relationship is also important to the use of IPA in which the experience of the interviewee is analyzed for meaning (Rajasinghe, 2020; Smith et al., 2009). As the instrument in this research study, it is relevant to analyze potential biases. My religious background is Seventh-day Adventist, and, therefore, I have close ties with the study of the Caribbean Seventh-day Adventists pastors. I am also very passionate about counseling and take seriously the no harm theory, which helped me to keep the balance with this investigation on my own church. As expressed later in this chapter, I kept a journal to monitor my reactions, I bracketed my reactions, and I remained open to feedback and supervision from my chair.

My role as researcher dictated that I design this study with the best strategy that could yield data that would ensure success in answering the RQs. This means pondering

the best way of selecting the participants within the selected geographical area that suited the criteria for this investigation. Upon identifying them, the researcher's duty is to make contact and initiate the establishment of a relationship (Kang & Hwang, 2021; Smith et al., 2009; Vitus, 2008). It is also the researcher's duty to ensure a natural setting is captured so that the participants are not influenced by the investigator's presence (Abu-Alhaija, 2019; Creswell, 2013).

As the researcher and interviewer, it was my responsibility to be in control of the direction of the interview and facilitate the conversations and be able to solicit information without promoting my own ideas (see Smith et al., 2009; Solarino & Aguinis, 2021). A collaborative interview approach is suggested in which both interviewer and interviewee are in a quality mode in their questioning, interpreting, and reporting (Kvale & Brinkmann, 2009). I employed these modes through doing a phone interview with each participant through a method where they could be seen, as I took necessary notes and records to ensure accuracy and reinforcements, in case they were needed after the live interviews.

I collected and analyzed the data in order to glean the meaning of answers given to suit the RQs. The coding was then done based on the themes that emerged. I then ascribed the meaning bearing in mind the participant's intended meaning and view, while focusing on their impact on the RQs. All this was accomplished under the premise that such shared experiences would help to answer the RQs and facilitate the understanding regarding how the Seventh-day Adventist Church in the Caribbean addresses the mental health consultations of their parishioners.

Methodology

Participant Selection Logic

The participants who volunteered in this research were selected from a pool of Caribbean pastors from the Seventh-day Adventist Church in the Cayman Islands, The Bahamas, The Turk and Caicos Islands, and Jamaica. The sample was also limited to male pastors as female pastors are very rare in the Caribbean and controversial due to the mixed belief of the parishioners on the subject of whether females should be considered pastors (Bumgardner, 2015; Dudley, 1996). This is a controversy that has been debated at the World Conference Session, the highest level of the SDA Church as they voted whether to ordain female ministers, which would have given them an opportunity to be presidents of the conferences or even the world leader; the decision was voted down by delegates from around the world (Boorstein, 2015). Given this, female pastors have a significantly different lived experience in comparison to male pastors, and while it is important to understand their experiences, they would likely be qualitatively different and require a separate study. Criterion sampling was used so that the cases selected were information rich and met the highest quality assurance (see Creswell, 2013; Daniel, 2019). They were then interviewed using the one-on-one interview method and an interview guide with open-ended questions and space to write the answers (Abu-Alhaija, 2019; Creswell, 2013; Kvale & Brinkmann, 2009). The interviews were also recorded.

The eligibility for participation was based on the criteria that included male Seventh-day Adventist pastors who (a) have acted as pastors for at least 5 years, (b) had consultations from members who experienced mental health problems, and (c) were

presently employed for an uninterrupted tenure. Pastors were invited to participate from a list of pastors from the Seventh-day Adventist Conference and Union. More information on recruitment is described under the procedures for recruitment, participation, and data collection section. In recruiting participants, I also use snowball sampling (see Leighton et al, 2021). Participants of my study were asked to share information about this study with other potential participants.

The participants in this study were purposefully recruited from various conferences in each union. Ten participants were selected to participate from the pool of pastors who qualified to be interviewed. A sample size of 10 to 12 in phenomenological studies is appropriate as recommended by Creswell (2013). When using a semistructured interview guide, a sample size of 12 participants is appropriate (Braun & Clarke, 2021). According to Fusch and Ness (2015), there is no universal sample size to reach saturation. Therefore, a researcher can make the decision whether the information is enough for replication. Saturation occurs when data collected render no new information (Braun & Clarke, 2021; Mason, 2010). I decided to recruit the first 10 pastors who responded to the invitation to participate in this study as long as I had at least two persons from each conference. I expected to reach saturation with this sample size.

Instrumentation

Demographic Questions

Demographic questions were used to begin the interview as shown in the Appendix. Such information proved to be important not only in ice breaking for rapport in the interview but also added context and other necessary information concerning

participants and described the sample (see Daniel, 2019; Smith et al., 2009). These questions sought information on their age, ethnicity, tenure in job, churches pastored, education level, and countries served.

Semistructured Interview Guide

The main format of data collection in this study was through a semistructured interview (see Appendix). An interview guide was developed to guide me in asking the relevant questions and rule out bias (see Kallio et al., 2016). The semistructured interview also inspires an atmosphere of sharing with uninhibited and focused expression (Holt, 2010). This semistructured interview not only creates an atmosphere of sharing but unlike the structured interview, it allows the flexibility needed for follow-up on particular experiences and beliefs (Abu-Alhaija, 2019; Smith et al, 2009). These interviews yielded rich information about how the pastors' experienced their parishioners' consultations.

The data collection method for this study entailed using a semistructured interview. The interviews lasted between 45 minutes to 1 hour. The interview was face-to-face for the participants living in the Cayman Islands and via Zoom for those in other countries. Recordings were done using a voice recording instrument and a backup recording. To ensure that there was enough information to analyze based on the answers provided by the participants, the interview questions were structured as open-ended questions (see Abu-Alhaija, 2019; Kvale & Brinkman, 2009), so I developed the interview guide following these guidelines. These recordings were both manual and electronically stored using codes to disguise the names of participants.

Procedures for Recruitment, Participation, and Data Collection

The following are steps that I took in the identification and recruitment of participants:

1. I first requested permission from the University Institutional Review Board (IRB) to conduct the research, furnishing IRB with detailed information on data collection, analysis, and all the measures to ensure ethical standards and participants' security.
2. On approval from IRB, I obtained permission from the higher organizations, the unions, both in Jamaica and the Bahamas. They were the Jamaica Union and the Atlantic Caribbean Union Mission. These unions were emailed a letter explaining the study details, the research target population, and the purpose for involving them in recruiting participants. The letter also described the short and long-term benefits of the study along with a declaration of the risk to the participant. I communicated to these officials the steps that I would be taking to protect the privacy of the church, the participants, and the information that I collected from the participants.
3. I then at this point contacted the Unions and reached out to the executive secretaries, representing the organization, who assisted me by sending out emails to the pastors of their fields. This email also bore my contact information so that the interested pastors could make contact.
4. The participants reached out to me through phone and email about the information they received in the email from the executive secretary at the union.

5. I then sent a copy of the letter with the informed consent form to the pastors, and they accepted the invitation by signing the consent form. Included in the inform consent form was (a) purpose of the study, (b) possible contribution of the study to the churches and society, (c) reason for invitation, (d) coverage of participation, and (e) participant eligibility criteria.
6. They consented to the study via email by responding "I consent." The informed consent is an important tool in research that helps to provide the potential research participants with the detailed description of the study (Creswell & Creswell, 2017). In this study, I used the informed consent form to inform the participants about who I was, the affiliate institution, and what the research purported to achieve. The informed consent document also had an explanation what I expected from the participants and the potential benefits associated with the research. I also mentioned the risks associated with the research and the steps that I took to ensure that the participants and the information would be protected. The participants were also assured that the signing of the informed consent form does not take away their right to terminate their involvement in the study at any stage of the research (see Creswell & Creswell, 2017).
7. After receiving the email with participants' consent, I coordinated with the participants to ascertain date and time to schedule the interview.
8. For the remote interviews, I used the HIPPA compliant version of Zoom. To conduct these interviews, I used a private office, and I encouraged the participants to do the same to ensure privacy and concentration and lack of disruption. This

private office was their home office, a place where they would not be interrupted. At the end of the interview, I provided a quick debriefing thanking the participants and telling them about obtaining results of the study and referral information. For the face-to-face interviews, I met participants at their church offices where it was private enough to conduct the interviews.

9. After the interviews were conducted, I transcribed the interviews. This helped me to engage more thoroughly with the content of the interviews.

Data Analysis Plan

Data analysis in this study follows the IPA guidelines. IPA data analysis is flexible, reflective, and interpretative with considerable room for maneuver (Larkin & Thomas, 2012; Raj Smith et al., 2009). Analysis is iterative and inductive, and it follows a flexible set of strategies. To begin the process of data analysis, the interview transcripts was thoroughly scrutinized, re-read, and audio files listened to at least twice to avoid missing vital information. During this period of familiarity, I looked for similarities, got ideas, and impressions, and these were recorded for future reference. Re-reading the transcripts and listening to the audio recordings more than once promoted understanding and accuracy in portraying participants' experiences and their connecting conceptualizations. At this stage, I kept a journal to monitor my initial impressions and ideas.

I then engaged in close, line-by-line coding or noting of the participants' claims and concerns. I paid careful attention to participants' accounts regarding people, places, the use of language, and description of context, which helped me understand the meaning

that participants make of the phenomenon. This was expected to be the most detailed and time-consuming stage (Cuthbertson, 2020; Smith et al., 2009). At this stage, the notes identifying these key areas of interest was marked on the left side of the copy of the interview transcripts. After the initial coding, I re-read the transcript and my notes, and I engages in a second level of annotations noticing similarities and differences within each interview. A database was used to present the material, thus allowing for enough spacing, which enables note taking and themes, as well as coding in a specific format.

Smith et al. (2009) and Cuthbertson (2020) describe the development of emergent themes as a major third strategy within the iterative analytical process. It was relevant to identify patterns across the interview, but also to mark contradictions or inconsistencies that may appear in participants' narration. I looked for alignments within the story, reoccurring feelings or perceptions, but also for contradictions. Summaries of initial patterns were described. Another related step was to search for connections across emergent themes (Cuthbertson, 2020; Smith et al., 2009). The development of a structure to illustrates the relationships between themes (Larkin & Thompson, 2012) was the next logical step. Once the themes in the data were recognized, I engaged in the process of mapping the themes to see how they are both interconnected and unique. The most dominant and relevant themes were highlighted, while others began to lose their relevance.

After the search for connection among themes was completed and a first thematic framework was developed in one full interview, Smith et al. (2009) recommend moving to the next case. I then repeated the process with the next participant's transcript. One of

the challenges at this stage was to remain open to new themes emerging from the interviews that followed (Smith et al., 2009; Smith et al., 2021). Any researcher may be inevitably influenced by the coding that was already completed in the previous interview. While completing the coding of subsequent interview transcripts, I attempted to bracket the ideas emerging from the first analysis; allowing for newer considerations and interpretations to emerge.

Once the thematic structure was completed in all interviews, the next step was to look for patterns across cases (Smith et al., 2009; Smith et al., 2021). The themes were compared across interviews. Comparing themes allowed me to address how different themes might come together or seem to break down or mean something different. I looked for consistency across thematic results. As a general guideline through the analysis, I was conscious of my own bias to adequately crosscheck, ensuring that codes and themes derived from the transcript and recording were solely evidence of the participants' experience. A journal was kept that allowed reflexivity as I recorded information as they are (Myers, 2019; Onwuegbuzie & Leech, 2007). I kept careful reflection, revision, and openness to chair's feedback throughout the evolution of data analysis.

After following these steps to analyze the data from the interview transcripts, the findings were presented in a coherent report. It is known that not all evidence may fit the patterns of the code or themes. As such, if this discrepancy emerges, the negative data will be documented so that a more realistic and valid perspective of the phenomenon is presented adding credibility to the study (Creswell, 2013).

Issues of Trustworthiness

Trustworthiness must be established to ensure the quality of the finding. Such trustworthiness was demonstrated through specific attributes including credibility, transferability, dependability, and confirmability. I followed Amin's guidelines and recommendations in ensuring quality in my study. The issues of trustworthiness and their application to this study are described next (Amin et al., 2020).

Credibility

The credibility of the research refers to the internal validity in qualitative research. Such credibility ensures that the study discovers what it intends to, based on the methodology of answering the RQs (Amin et al., 2020). This is beautifully described as that confidence that is placed in the experiences told in the research findings (Macnee & McCabe, 2008). In this research, credibility was established by dedicating allotted time to become acquainted with the participants, allowing them to be comfortable enough to give deep and honest information that would ensure an informative study. A journal was kept that allowed reflexivity as I recorded information as they were (Myers, 2019; Onwuegbuzie & Leech, 2007). Peer checking was also used for feedback as I checked not only with my committee, but with peers and other experts that I have access to for ideas and academic guidance and especially in drawing the conclusion of the study (Bitsch, 2005).

Transferability

Transferability refers to the concept that the findings of the study can be applied to another similar context. It is the desire of any researcher that their study is able to be

transferred and fit similar contexts using other respondents (Amin et al., 2020; Bitsch, 2005). I ensured this through the presentation of detailed and profound descriptions of the data from the beginning to the end of the process. This comprehensive explanation will make transferability easy, should another researcher want to replicate the study, and even in this case, that the study of the clergy of the Seventh-day Adventist Church in the Caribbean can be made applicable throughout the world church (Amin et al., 2020). Purposeful sampling was also be used to ensure that key persons are used to guarantee that rich information are collected from the particular persons who have the experience (Ary, et al., 2010; Schutt, 2006; Stahl et al., 2020).

Dependability

Dependability refers to the consistent stability of the data over time. Dependability is very important in this qualitative report as it is how the research stands up to scrutiny over many years. Such findings, on replication, would prove similar and show consistency in its process (Amin et al., 2020; Bitsch, 2005). Several strategies can be used to establish dependability in qualitative study. The first is the evaluation of the findings by the participants to see if they match up with the data they contributed (Cohen et al., 2011). Bowen suggests the application of an audit trail which involves an examination of the enquiry process showing details of the raw data, interview and observation notes, test scores and others (Bowen, 2009). There is also the suggestion of replicating the steps by two or more researchers so that any inconsistencies in the compared results can be addressed in order to prove the research is more dependable

(Amin et al., 2020; Ary, et al, 2010). I used the audit trial and included the interviews and details of my analysis procedure and processes.

Confirmability

Confirmability refers to comparable concepts of objectivity in quantitative research and it is attained by indicating that the study's results represent the responses of the participants as opposed to the subjective interpretation of the researcher (Amin et al., 2020). It is an establishment that the data and its interpretations are true and not just biased (Amin et al., 2020; Tobin & Begley, 2004). This research's confirmability strategy was accomplished through reflective journaling. Therefore, all processes and happenings during data collection was detailed in this journal and used for review and reference throughout the study (Myers, 2019; Bowen, 2009). Reflective journaling has helped me to ensure that my biases do not interfere in the research process. It is hoped that should any bias be exhibited, that both peer reviews and my chair committee will decipher such a pattern and provide the necessary feedback in order to have this rectified. My professional training has taught me well to be aware of and avoid my personal biases not just in treatment but in interviews, and certainly throughout the research. Therefore, should this approach fail, other strategies will already be put in place to address this issue. Such strategies are peer and committee feedback. A journal was also used to jot down details of the research process with a strategy of reflecting. This included completing a thorough bias check throughout the process b bb when necessary.

Ethical Procedures

One of the main considerations when conducting research that involves human participants is addressing ethical issues. The essence of ethical research is to balance the benefits of research with the harm such research may cause participants or other stakeholders. In protecting the participants and the integrity of the research, ethical considerations must be established. Such ethical issues include IRB approval, informed consent, data security, and voluntary participation. IRB approval for the study is # 07-06-22-0485346. To ensure that the rights of the participants are protected, IRB approval must be obtained. I presented the procedures that will be followed in order to minimize the risk to participants in the IRB report. Before soliciting any data, IRB approval was obtained in order to avoid conflicts that may arise while dealing with participants.

Informed Consent

Informed consent from the participants were sought prior to interviews. Participants were given information about the study and its process and how the information garnered from the interviews will be utilized. Informed consent documents have been developed and are placed in the appendices (Smith et al, 2009). Participants has a chance to view and question the researcher thoroughly before making the decision of participating. They were required to sign the informed consent document before the time of interview and also review it at the beginning of the interview process (Creswell, 2014). The form will also include information about the researcher's role and the part each play at the interview. They were also be informed of the institution with which the

researcher is affiliated and the purposes of the study in which they are invited to participate.

Data Security and Participant's Confidentiality

It is important to uphold the confidentiality of the participants. This was ensured by developing ways to make the participants anonymous. Therefore, each interview transcript was assigned a number, and identifying demographic information will either be removed (Abu-alhaija, 2019; Mozersky, 2020). I am the only one with the key linking the participants' name with the number assigned; and I have kept this list to contact participants. Once data collection was completed, I eliminated the key and all other data remaining was de-identified. All this information was shared with the participants, so that they were aware of how they would be protected, should they choose to participate in the research (; Mozersky et al., 2020; Smith et al., 2009).

The data was stored and protected in a password protected computer. I ensured that the voice recording was of a high quality. In order to account for the total information a master list of all the interviews were created. The researcher is also cognizant of the fact that the data should be kept after use for approximately five years and then all records should be destroyed (Creswell, 2017; Launderer et al, 2020). Those who have access to such files should be limited by the internal auditor and the Walden dissertation committee.

Volunteer Participants

All the participants in this research is voluntary. Therefore, friends, family members, or relatives of the researcher were not be recruited, in order to minimize

conflict of interest. Participants can quit the study at any time after signing the consent form, and may ask to have all of their data erased even if they have started their participation in the study. This decision has to be communicated in writing and phone conversation. The participants were compensated for their time with a gift card from their conference's Adventist Book and Nutrition Centre in the amount of $25.

Summary and Conclusions

This chapter outlined the methods that were implemented in making this research a reality, this phenomenological study explores the Seventh-day Adventist Caribbean pastors' methodology in addressing their parishioners' mental health consultations. In order to achieve the best results to answer the RQs established strategies were used. Qualitative research was employed to explore ways of perceiving this phenomenon as the persons who experience it speak first-hand telling their stories. The purposeful selection of participants was employed to get the best and deepest data from the selected individuals. Many strategies were implemented to manage researcher's biases such as peers review and committee feedback, participants reviewing the results, and coding comparison by multiple persons. A journal will also be used to record details of the research process as a reflective strategy. Finally, for ethical consideration, I sought and obtained permission from the IRB before interviewing and participants were able to make informed consent on their decision to participate. On approval of all this then the final chapters that follows chronicle the data findings and outcome.

Chapter 4: Results

The purpose of this qualitative phenomenological study was to explore the Seventh-day Adventist Caribbean pastors' experiences addressing their parishioners' mental health consultations. The first research question for this study was: What are the Seventh-day Adventist Caribbean pastors' experiences addressing their parishioners' mental health consultations? The second question was as follows: How do Seventh-day Adventist Caribbean pastors describe the training they received to serve their parishioners' mental health consultations? This chapter includes a discussion of the setting in which I conducted this study, participant demographics, the method of data collection, the techniques that I used in data analysis, the evidence of trustworthiness, and the results of the study.

Research Setting

The sampling strategy that I used in this study was criterion sampling. Criterion sampling ensures that information is rich and meets the highest quality assurance (Creswell, 2013; Daniel, 2019). Therefore, I sought participants who were Seventh-day Adventist pastors and had experience addressing their parishioners' mental health consultations. The participants came from a common context and had shared experiences in common (see Compton-Lilly et al., 2014). They met the following criteria: (a) acted as pastors of the Seventh-day Adventist Church for at least five years, (b) had consultations from members who experienced mental health problems, and (c) were presently employed for an uninterrupted tenure.

I interviewed the pastors on Zoom in a private setting where the participants were comfortable. Two participants were interviewed and recorded face-to-face in their pastoral offices, and the other eight were done on Zoom. Before the interviews, the participants had received written instructions about the process, which included criteria for participation, confidentiality, the nature of the study, and the opportunity to discontinue at any time. The consent form included the procedures and had additional information, such as sample questions and instructions on how to consent. All 10 participants consented, and all went through with the interview.

I am unaware of any personal or organizational conditions that would have influenced any of the participants at the time of the interview that may have affected the results. One participant was a second-language English speaker, and the recording was distorted. I had to have him clarify a significant portion of his interview answers a few days later.

Demographics

In order to qualify for this study, each participant had to be a male Caribbean Seventh-day Adventist minister in active service with at least 5 continuous years in service. The demographic information for each of those nine participants is displayed in Table 1

Table 1

Participants' Demographic Information

Identifier	Age	Education level	Ethnicity described	Time served	Church served	Countries served
Pastor 1	42	MA	Afro Carib.	6	2	2
Pastor 2	58	MA, C. Psy.	Negro	6	10	2
Pastor 3	36	MA	Haitian	6	5	1
Pastor 4	45	MA, Chaplaincy	Black	22	12	2
Pastor 5	53	MA, Ed. Psy	Hispanic	26	15	7
Pastor 6	31	MA	African	6	7	1
Pastor 7	38	MA	African	16	30	1
Pastor 8	28	BA, Psy. Cand.	Black	5	11	1
Pastor 9	35	MA, C. Psy.	Black	13	35	1
Pastor 10	39	MA, Chaplaincy	Black	15	15	2

I identified the participants as Pastors 1 through 10, with the numbers in order of interview date. Each participant presently served as a pastor of at least one church in the Caribbean area that ranged across the following Caribbean countries: the Bahamas, Turks and Caicos Islands, the Cayman Islands, and Jamaica. The participants first answered a series of demographic questions, which showed that they had an age range from 36 to 64. The participants all had a master's degree, with just one participant who had not completed his graduate studies. There were nine Afro-Caribbean pastors and one Hispanic pastor. The time these participants spent serving the church ranged from 5 to 26 years, and the number of churches they served ranged from two to 26. Five of them served only one country. Four served two countries, and one served seven countries.

Data Collection

There were 10 participants in this study. After obtaining Walden IRB approval, I sent letters to the targeted unions: the Atlantic Caribbean Union and the Jamaica Union.

The unions sent invitations to all their pastors with a brief description of the purpose of the study, criteria, and my email address, inviting them to respond to me if they wanted to volunteer. Eleven participants responded to me, saying that they would like to participate in the study. I sent each respondent a consent form by email, and they responded to me with the words "I consent." I interviewed the first 10 volunteers.

The interviews were scheduled over 2 weeks, and I conducted them via Zoom with eight participants from the Bahamas, Turks and Caicos Islands, and Jamaica. I conducted two interviews face-to-face in the Cayman Islands, where I live.

Each interview lasted between 45 to 60 minutes. I used the first 5 to 8 minutes for introductions and essential details of the consent form, such as the voluntary nature of the study and the participant's right to decline participation at any time. The interviews were audio recorded, and automatic transcripts were made. I then verified these transcripts with the recording to ensure the correct information was on the transcript. The transcripts and audio files were stored and backed up in a Microsoft file labeled Pastor 1 to Pastor 10. This folder is password-protected on my computer and backed up on an encrypted cloud file.

Data Analysis

After completing the interviews, I verified and stored the Zoom-generated transcriptions. Data analysis began with the use of the IPA process. Here, I read each case line-by-line while analyzing the data with a view of coding the concerns and understandings of each participant (see Nassaji, 2020; Rajasinghe, 2020). The emergent patterns making up the themes were identified in each case. After reviewing the entire

document, each case was revisited and examined across multiple cases to identify the emerging patterns (see Nassiaji, 2020; Rajasinghe, 2020).

I used a large matrix table of the participants in this process. From this large matrix table, I outlined all the questions and responses and developed and analyzed the coding, cluster, and themes of each interview question with a view of the whole structure. My chair audited the coherence and plausibility of the interpretation.

At this stage in the process, I became familiar with the concerns of the participants and the coded information. I used psychological knowledge to assign meaning to the participants' concerns and experiences. At this stage, I was able to put the information in context and interpret the experiences that were related to the interviews (see Nassaji, 2020; Rajasinghe, 2020).

I generated themes during the analytic process as I became more familiar with the data. I asked pastors about their daily activities at the church, and the themes I generated fell under the listing of visitation, administration, and meeting with people. As an example of the visitation code, Pastor 2 stated, "My activities in a district would comprise of visitation… We visit the shut-ins and NGOs or disenfranchised, taking some items to them. And then administrative work sitting in the office." Pastor 4 said, "I also use that time for visitation, returning phone calls, and that kind of stuff." Pastor 6 commented, "My daily routine would include from 10 am visitation of sick and shut-in members."

Evidence of Trustworthiness

Researchers must capture genuine and honest findings so that the information in a study is credible and trustworthy (Amin et al., 2020). To establish the trustworthiness of

qualitative research, these four quality criteria should be observed: credibility, transferability, dependability, and confirmability (Yin, 2013). I achieved credibility with the use of the Zoom interview, which provided high-quality audio and transcription of the data. Data were then verified with participants where doubts arose in the transcripts.

Credibility

To achieve credibility, I followed the instructional method in data collection and analysis. I established credibility by dedicating allotted time to become acquainted with the participants, allowing them to be comfortable enough to give deep and honest information. The process that entailed listening, verifying, rereading, coding, categorizing, and identifying themes and patterns ensured the validity of the research (see Ningi, 2022). I also used peer checking for feedback and checked with my committee, peers, and other experts for ideas and academic guidance, especially in drawing the conclusion of the study (see Bitsch, 2005; Li, 2023). I continued this kind of credibility check throughout the research as I made connections between the data and the findings. I also ensured that I resolved all possible biases on my part.

Transferability

Transferability in qualitative research refers to the extent to which the results of the qualitative research can be used in other settings. Studies should be easily transferable and fit similar contexts using other respondents (Amin et al., 2020; Bitsch, 2005). I ensured transferability by presenting detailed and profound descriptions of the data from the beginning to the end of the process. This comprehensive explanation makes

transferability easy should another researcher want to replicate the study. Likewise, a replicated study of Seventh-day Adventist clergy worldwide would be possible.

Dependability

Dependability in qualitative research is the ability of the researcher to ensure that the research process is logical, traceable, and well-documented for application to another context (Amin et al., 2020; Patton, 2015). I achieved dependability in this research by saving data from the audio file, transcripts, and the analysis worksheet with its detailed processes.

Confirmability

Confirmability in a research study means to establish that the research conducted was real and not just imaginary but derived from the data (Amin et al., 2020; Patton, 2015). My dissertation chairperson checked the confirmability of my study at each step of the process. The procedures I followed in this study also strengthened the confirmability as they affirmed not only the reality of the data but enhanced the accuracy and trustworthiness of my findings.

Results of Study

I conducted this research to understand how pastors from the Seventh-day Adventist church address their parishioners' mental health consultations and to explore pastors' training to address these consultations. With the use of Zoom interviews, 10 pastors were asked a series of questions to answer the following questions:

RQ1: What are the Seventh-day Adventist Caribbean pastors' experiences addressing their parishioners' mental health consultations?

RQ2: How do Seventh-day Adventist Caribbean pastors describe the training received to serve their parishioners' mental health consultations?

Three themes emerged from the first RQ: recognizing mental health issues, family issues are significant concerns, and decisions to refer. One central theme emerged from the second RQ related to training experience. Table 2 illustrates the themes and related RQs.

Table 2

Themes, Meaning, and Related Research Questions

Themes	Meaning	Key thematic topics
RQ1: What are the Seventh-day Adventist Caribbean pastors' experiences addressing their parishioners' mental health consultations?		
Recognizing mental health issues	It refers to how pastors described how they identified potential parishioners' mental health issues	- Lack of coherence - Abnormal behaviour - Stress from family problems - Depression
Family issues are significant concerns.	Family issues refer to the consultation the pastors received most often during their work.	- Marital challenges - Premarital preparation - Parenting
Strategies and decisions to refer	Pastors have trained mental health counselors in their congregation or at the conference to whom they refer their mental health cases.	- Pray - Listen - Assist where I can - Refer when I cannot help
RQ2: How do Seventh-day Adventist Caribbean pastors describe the training received to serve their parishioners' mental health consultations?		
Insufficiently trained	Pastors are trained initially at the Bachelor's level, where they take a course called Pastoral Counseling. Should they do the Masters courses, they take another counseling course.	- Trained in psychology - Read widely on the subject - Consulting with others - Seminar and workshop

Theme 1: Recognizing Mental Health Issues

The first theme generated from the data was recognizing mental health issues. It refers to how parishioners identify potential markers of mental health issues in their parishioners. This theme has four primary descriptors that account for signs that pastors

observe in their parishioners, which, in turn, help them identify mental health issues. These primary descriptors include parishioners' lack of coherence, abnormal behavior, stress from family problems, and depression.

Lack of Coherence

Most pastors recognize that their parishioners have mental health problems when they listen to them and realize a lack of coherence in their speech. Pastor 1 stated, "When I see a member having challenges in terms of how they are reasoning. When their reasoning skills are off, it gives me a reason to pause, of course." Pastor 5 said, "When they are inconsistent in their narrative." Pastor 2 elaborated, "You know by listening to the person, you will discover if the person is struggling with cognitive behavior."

Abnormal Behaviour

Another pattern is to recognize possible mental health issues related to abnormal behavior. Many pastors recognize mental health issues when their members display inconsistent behavior. For example, Pastor 5 said, "When someone acts in a disorderly manner, it affects the person to reason." Pastor 8 expressed this as a "person who does not think so that they might do things out of the way or out of the norm." Pastor 1 provided this example:

> We had this young lady who called me in; she heard these voices, and she was depressed. She had suicidal ideations, and she reached out to me via telephone, so I listened to her, gave her some advice, and referred her at this time; she wasn't on island at the time, she was in the UK, but as the pastor, because she comes to this church, she's a student and I refer her, she got some assistance overseas.

Stress From Family Problems

Many pastors stated that stress from family problems was how they recognized mental health problems in their congregation. Pastor 5 said that he has members who "were dealing with a pressing family issue that can lead to some mental disorder." Pastor 2 has been trained in counseling psychology, and he also has seen family problems in their parishioners, which brought great stress. He said,

> Yes, one aspect of my training dealt with family therapy. Many of them have family issues, which is the source of their stress, and that aspect of the training in family therapy was most beneficial counseling therapy; the actual counseling course where you are taught how to use the modalities to achieve the best outcome that was the most important.

Pastor 7 said, "There were marital problems among even choice leaders." These choice leaders are prominent members who are officers of the church and prominent members of the society.

Depression

Some of the pastors identify mental health issues when they recognize depression in their members. Pastor 7 says he encountered individuals with "depression and depressive modes." He related an encounter, which he summed up by saying,

> The symptoms are sometimes displayed, you know, characteristics of some mental issues are challenging. For example, a mother brought her son who was seeking to go to the HEART training program, and on the HEART form, they asked the question about depression, and he said that he was depressed. Now

because he was depressed, they needed to come to, you know, get an assessment done to see his suitability to be in an educational program, skills training program, and while having the conversation with him, it was difficult with the mother and difficult for him because he was expressing quite a bit of things that had impacted him that clearly has made him enter into a sphere of, you know, depressive episodes. I find it to be very challenging to cope with those kinds of issues, and it can be an emotional broth, nerve-racking to say if I were to describe it like that.

Pastor 6 described his encounter with depression among his parishioners:

Yes, most persons have mild to moderate depression or anxiety and so the sessions would generally be surrounded by how they would cope. Most times, it is two sessions; I would want it to be about five sessions, really. Once they get the opportunity to share and once we're going into some of the tools that they can utilize to help with depression and anxiety, I get the kind of limited-time scenario. Of course, we talk about demographics and family history; spend some time focusing on what is going on in your life and how you can make more sense of it. For instance, people just want an outlet, a quick fix, and want to get on, so you'll find most of the consultations are short and just make sense when persons are at that breaking point when they will kind of come. I think that has a lot to do with the area where I pastor, as in the urban area, people don't really have time. They don't really have that sort of time to spend on coming to five or seven sessions; they have a short time, this is a matter that they need to address, and sometimes I will call them in, you know, being in the field I noticing that Okay, maybe as a

> leader, you're not coping so well, or maybe you've had a death in the family, and months later we're seeing the changes in your home you operate on you execute or functions and so sometimes I'll call them in. I'd say people just want a quick fix. People generally genuinely want to address their consultations immediately.

Theme 2: Family Issues are Major Concerns

Half of the participants believe that family issues are a significant concern and are the most common type of parishioner's consultation. This comes up very often across many interview questions—family issues related to marital challenges, premarital preparation, and parenting.

Marital Challenges

Most of the pastors believe that marital challenges are the most frequent mental health consultation they have had. Pastor 1 states, "The most common type would be premarital preparation and marital challenges. Pastors 2, 3, 5, 8, and 10 also cited marital challenges as the most frequent mental health challenge. Pastor 10 stated, "What I found common is family issues. These concerns may be a relationship, maybe it's the children, you know". Pastor 2 made his point in his report by stating,

> Yes, there was an example of one who was to the point of divorce and very stressed by the behavior of her husband. She is a member of the church and stressed to the point that she could not function at church. Stressed about the point that she was not really coping with life, and it took several sessions. What I did was to really do an assessment and a treatment plan for her, after which we followed the treatment plan, and she was back on her feet. I gave up since the

husband did not want to come to therapy. I gave her some strategies to use on her own where husband is concerned and evaluate where she was going wrong and taught her how it is to relate to him and how it is to deal with depression when depressive thoughts commence or the depressive symptoms arise, and it was a success story.

Premarital Preparation

Some pastors also cited marital preparation as one of the popular consultations. This is also called premarital counseling by some participants, where pastors help parishioners sort through their issues in preparation for marriage. Pastor 10 stated it this way as he credits an author for his knowledge to deal with premarital counseling:

> To deal with this passionate mental health. You know, pastoral counseling, and you know, premarital counseling, and so forth… Oh, yes, what I have done is recognize the chronic need for intervention, and people are coming, and by virtue of my position, they feel that I must know so on my learning, I know that I don't know. So, what I have done, you know, I use resources, quite a number of resources. I have informed myself in certain areas. I have taken certain programs and books that I have, like John Gottman. John Gottman, I believe, is one of the best that I've seen in terms of premarital marital counseling mental health issues. He's scientifically based, excellent when it comes to um the human behavior, root cause, and so forth, and how to mitigate, how to provide professional intervention. So, I've informed myself with certain ah counselor, psychologist, normally. I believe it's another good guy, um Gary Chapman is, it's more of a prescriptive

> intervention, you know, but it is based on what I need or based on the needs. I have done my best to be informed and get the necessary help that I need; anything outside of that with respect to chronic and acute care, I'm making a referral.

Parenting

Parenting is another topic coming out of the family issues theme. Few pastors stated that the family issue included dealing with the children. Pastor 10 stated,

> These concerns may be relationships, maybe it's the children, you know. Those are the themes that I'd see most common" … Ah, well, in that light I would like to, especially when I'm dealing with the marital counseling. You get to understand the root of certain behaviors. They have to see it better, or when I'm dealing with challenging teens and children with parents come in to me asking me to, you know, be a mentor for their children or to deal with certain traits of behavior.

Pastor 3 said, "I conducted some counseling sessions for those who have difficulty to getting over bereavement or grief and also conflict resolution and conflict issues, life issues, marital issues, and parental issues."

Theme 3: Strategies and Decisions to Refer

The third theme generated from the data was related to what strategies pastors use to handle their parishioners' consultations and when they decide to refer out. Most pastors talk a lot about referring to various interview questions I asked during the interview. Key thematic topics included praying, listening, assisting where I can, and referring when I cannot help.

The counseling sessions of the pastors seem to be similar to those of the mental health professionals, mainly for those pastors trained in counseling. Most pastors were trained in mental health counseling; that is, six of the ten participants. Pastor 2 expressed this by stating,

> In the vestry, I would use the processes of cognitive behavioral therapy, and I would use positive psychology and intersperse them or add them as modalities within the vestry session and also use this skill sets in the family development and the family life studies to deal with the issues. Where stress is brought about by family relations, I use the modalities in family therapy to deal with them, so we have had great success; yes, the successes have been great. Truly.

For those who are not trained, that is four of the participants; it is a matter of listening to see if it is something simple enough that they could deal with or if it is something they would need to refer. Pastor 4 reported,

> I would listen initially. But for me, again, I would always prefer I would always refer because that's not my strong point. I would always refer because I do have a specialist in that area in my church at this time, and so I would refer to them or to whoever is keener in that area.

Pray

Most participants stated that they pray before they start the consultation as God is the source of all wisdom. Parishioners also ask for prayer, using the prayer request as an icebreaker to speak to the pastor privately and then get to their real problem. Pastor 1 said, "So I pray to start the consultation, and I ask, you know what do you think your

challenge is?" Pastor 3 stated that "they came and asked for prayer, and so as we develop this rapport with a person, so they can feel free to speak, then I realized that the person needs more than prayer." Pastor 2 said,

> So that's really where, and I have prayed to God for the competence to really assist parishioners where these concerns may arise. I really ask God to grant me the competence, and he has really blessed me. He has not disappointed me.

Listen

Most pastors state that in addressing their parishioner consultations, they do much listening initially because they learn a lot from listening. Pastor 3 stated, "Normally. I sit down, you know, I sit down to listen. Because active listening is very important and developing that openness." Pastor 4 said, "I would listen initially." Pastor 2 stated, "You know, by listening to the person, you will discover if the person is struggling with cognitive behavior or personality disorder." Pastor 1 stated, "But the majority of it is, it's listening before trying to give any counsel."

Assist Where I Can

Most participants say that they assist. This assistance may mean that they apply therapy because they are trained, or it may mean that they have someone in their congregation or conference who helps. All members are helped in some way, whether through the therapy done by a pastor, by referral, or by prayer. Pastor 5 stated, "I deal with issues that I am able to address based on my capacity as a counselor and spiritual adviser." Pastor 2 said,

> In the vestry, I would use the processes of cognitive behavioral therapy, and I would use positive psychology and intersperse them or add them as modalities within the vestry session and also use this skill sets in the family development and the family life studies to deal with the issues" ... Well, if it was that I was not trained, I would refer, but since I'm trained and I know it's not an ethical issue but it's a dual relationship of some sort. I proceed by the use of a modality called Solution Based Therapy.

Refer When I Can't Help

The last key topic relevant to this theme is the decision to refer when participants felt they could not help. This topic was relevant among almost all participants. Pastor 5 said, "When the problem is even beyond a parishioner's capability, I may refer them to a higher authority in health. Pastor 1 said,

> So, if I realize that there is a mild challenge that maybe just emanated from stress because most of my parishioners have high stressed, high-stress jobs, so my advice would range from things like getting adequate sleep, thinking nutrition, exercise, and where that is insufficient, then I transit or refer them to some to someone else.

Pastor 4 stated, "I would listen initially. But for me, again, I would always refer. I would always refer because that's not my strong point." Pastor 6 said,

> Well, firstly, I try to explore what is happening. Number two, then to see deeper meaning and understanding and insight through probing questions, asking for

> examples, asking for descriptions. Then, if I'm unable to identify what the issue is, I would refer the person to a suitable counselor.

Theme 4: Insufficiently Trained

The second and final RQ concerned with how the Seventh-day Adventist Caribbean pastors describe the training they received to serve their parishioners' mental health consultations. The main theme reflected that participants felt inadequately trained to address their parishioners' mental health consultations. The critical topics related to this theme were: trained in psychology, read widely on the subject, consulting with others, seminars, and workshops, and insufficiently trained in seminary. Of the 10 participants, six had mental health training at the master's level, and one of the four untrained is acquiring a master's in psychology. Most pastors believe that the mental health training they received in their pastoral training was insufficient to meet the job's demands. Pastor 5 stated,

> I don't feel fully prepared because I don't consider myself an expert psychologist, but I have been trained in some areas to know the scope of the problem is beyond my capabilities. So, when I do referrals, it's because I am not fooling myself that I am an expert in that area.

Pastor 8 spoke about the inadequacy of the undergraduate program to prepare pastors to face mental health consultation on the job. He said,

> I really don't think the level of exposure that pastors have is sufficient to our practice as ministers. I think it is underrepresented in the undergrad program, and

> in order to benefit from it, someone will have to deliberately want to do a master's in psychology or a related field, and not all of us pastors have the interest.

Pastor 1 spoke to the inadequacy of the one course, but it met the objective of giving a foundation. He stated,

> I think there was just one chapter of 28 in the course that we had to go through that specifically focused on mental health, which I think is inadequate. I think they did well. I don't wanna say it's inadequate because the objective of the course was to give you a foundation rather than you building in any particular area.

Most pastors affirmed that they did an undergraduate course during the Bachelor's level and one during the graduate level in seminary. Pastor 7 stated that the undergraduate course was not in-depth but helpful. He said,

> We did have to do for undergraduate courses related to the helping profession. Of course, those courses were not as in-depth for a practitioner, but they did allow for basic insight and understanding of actually what it requires. And I paid attention to those things when I was at school.

Pastor 1 believes that he does not know enough to work with clients. He expressed this by stating, "I'm not that knowledgeable. In undergrad there was one course, um like a combination of formal schooling on the undergrad, at the graduate level; also, we did an elective in counseling."

All pastors expressed that the training they received to assist with their parishioners' mental health consultation was insufficient as it was, in reality, just one course. Some have expressed how helpful it could have been if, in their studies, they

carried the counseling course for a year instead of a semester due to how important it is to their jobs. Others thought if they had better advice as to choosing electives, then that would have been one way they could have gotten more training in the area. Pastor 2 expressed it this way:

> The training I received in my theology program was basically inadequate, one course in pastoral psychology. That really wasn't adequate to deal with parishioner's problems. In the master's degree program, that's where I really received training. And in my quest for licensure to update the licenses in the continuing ED hours, I believe I truly receive grade levels of intense training.

Pastor 3 expressed it this way:

> I know that the training that I receive is very limited to dealing with mental issues; however, with the basic training that we receive, I am able to create an atmosphere where the member can feel free to talk to me and build a relationship and help them to grow. So right now, I know definitely there's a lot to be done in this area.

Pastor 5 said,

> There was very limited training provided at our Adventist school within the theology department. We receive some peripheral training, which is the platform to continue upgrading our knowledge on mental health and how to deal with those prevailing issues in the churches. I have received a master's degree in psychology, which has helped me to be better equipped to help people with mental health problems.

Trained in Psychology

Most of the pastors attained extra training in psychology and chaplaincy. This gave them a feeling of adequacy in assisting parishioners with mental health consultations. Pastor 2 expressed this by saying, “In the master's degree program, that's where I really received training. And in my quest for licensure to update the licenses in the continuing ED hours, I believe I truly receive grade levels of intense training.”

Pastor 5 also expressed how having a psychology degree has equipped him for service. He says, "I have received a master's degree in psychology, which has helped me to be better equipped in helping people with mental health problems." Pastor 4 talked about how his training in chaplaincy helped:

> Now, the training that I have in that regard comes from the chaplaincy program. The reality is that in my, in my pastoral training, there's little to none, but because I have done the chaplaincy program with the country, they provide mental health training.

Read Widely on the Subject

Most pastors who did not feel that they were adequately trained reported that they read counseling material to help gain knowledge for the job. Pastor 1 says, "Then I read, so I would say that most of the stuff comes from independent reading and application as much as possible." Pastor 7 said reading is his number one means of knowledge for the job:

> Number one, a lot of reading…. So learning, reading um, engaging in the sphere with colleagues… We need to read more. There is a book that I like that I use in

> my accounts name by Gary Collins. Um. It's a Christian Guide to counseling, and I think it's very effective. We need to understand that reading matters, and in line with that, presentations also are necessary.

Pastor 1 pointed out how he got his knowledge. He said,

> There is no rubric to measure whether I've learned or the extent to which I've learned or to have any mock interviews or how to do intake and assessment and those kinds of things. It's just, it's just reading and questions that are outlined there; those are the kinds of questions that I tend to get into.

Consulting With Others

All of the pastors have consulted at some point in their work in order to help parishioners. They consult with other pastors trained in counseling or with the mental health counselor the conference provides or the national counseling organization available to the public. Pastor 7 expresses this by saying,

> Yes, I consulted a lot because there was an onsite counseling centre with three or four professionals, and so whenever there was a challenge, I would frequently consult them because, at that time, I was church pastor at the church, and I also assistant Dean of men so if I observe an unusual behavior with residents that I cannot interpret or make sense of, then I would call him in asking what's happening. I would not run that by the counselor. Well, what's happening here helps me make sense of this because, you know, in that community, persons were more sceptical of going to the counselor in the university setting, and then where

> the counseling office was located, it's like you know you go in there, and there is this label that you're mad once you go in for any kind of counseling.

Pastor 2 expressed his consulting experience by saying,

> Yes, so um I would have. So there are other pastors, and we would talk and mostly consult. They would share the cases with me, and those were pastors who were very much in the area of mental health as well. They share the cases with me, and I would give them feedback and also guide them as to how to deal with that problem. I would share with them stories as well or cases as well, not giving the name or the location of the client but only to draw references and to give examples.

Pastor 8 stated that he has had success with consulting in most cases, but in other cases, they are far gone. He said, "Yeah, my experience. Um. It has been great in terms of the experiences; consulting has been great. Um! Sometimes I see changes. Sometimes they're not, but you know there are some situations that are far gone."

Seminars and Workshops

In order to keep up with the consultation of members, a few pastors seek out opportunities to attend seminars and workshops. These seminars serve as continuing education for the trained pastors and education for the untrained. This is expressed by Pastor 6 when he said, "I have received a master's degree in psychology, which has helped me to be better equipped in helping people with mental health problems. I have also attended seminars and have read widely on the subject of mental health."

Pastor 7 talked about the many ways he tried to acquire knowledge in order to help parishioners because the undergraduate course was not enough:

> In school, we did have to do an undergraduate course related to the helping profession. Of course, those courses were not as in-depth for a practitioner, but they did allow for basic insight and understanding of actually what it requires. And I paid attention to those things when I was at school—so learning, reading, um, engaging in the sphere with colleagues. Ah, you know, going to seminars as well because I have been to quite a few seminars on this. So those are ways that I have actually exposed myself, and I read a lot.

Summary

This research was conducted to explore the Seventh-day Adventists Caribbean pastors' experience in addressing their parishioners' mental health consultations. The main RQ for this study was as follows: What are the Seventh-day Adventist Caribbean pastors' experiences addressing their parishioners' mental health consultations? The second question was as follows: How do Seventh-day Adventist Caribbean pastors describe the training received to serve their parishioners' mental health consultations?

Based on pastors' accounts, they can recognize mental health issues. They recognize mental health issues when their parishioners show a lack of coherence, abnormal behavior, stress through family problems, and symptoms of depression. The foremost and most frequent concern for parishioners is family issues. These family issues come in the form of marital challenges, premarital preparation, and parenting.

In the pastor's decision to refer parishioners, it is discovered that they pray before consultation as God is the source of all wisdom. Parishioners also ask for prayer as a means of getting to the pastor with their real problem. Pastors say they do much listening initially as they learn a lot from listening as it relates to knowing the state of their consultants.

Most participants say their assistance to parishioners may be therapy due to extra training in psychology, counseling, or chaplaincy. Parishioners are also helped by professionals in the congregation or employed at the conference. Others may be referred, but everyone is helped one way or the other. Pastor talked about referring a lot at various points in the interview. At no point do they not help their parishioner when consulted, but when they cannot help, they refer them to those who can help.

The second RQ focused on the training the pastor received to deal with their parishioner's mental health challenges. Pastors thought that they were insufficiently trained to deal with the mental health consultations of their parishioners in their original theology program. They make up for this insufficiency by doing additional training in psychology, counseling, or chaplaincy. Many who did not continue training in counseling read widely in the subject area.

The pastors reported that in their undergraduate course in theology, they have only one counseling course, and there is one if you continue to the master's level. Most pastors consult with others in order to help parishioners. This may be a trained co-worker, a professional counselor in their congregation, or a professional counselor employed by the conference. Consulting is a successful way of helping parishioners.

Pastors also reported that in their effort to gain competence in assisting parishioners with their mental health consultation, they do continuing education courses. This assists licensed pastors trained in mental health to maintain licensure, and others attend workshops to learn what they can to assist parishioners.

All pastors expressed that the training they received to assist with their parishioners' mental health consultation was insufficient as it was, in reality, just one course. Some have expressed how helpful it could have been if they carried counseling for a year due to how important it is to their jobs. Others thought if they had better advice as to choosing electives, then that would have been one way they could have gotten more training in the area. Below is Chapter 5, with an outline of the findings of this research. Included in this chapter are the introduction and interpretation of the findings. Limitation of the study, recommendations, implications, and the conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this phenomenological study was to understand how pastors from the Seventh-day Adventist church address their parishioners' mental health concerns and to explore pastors' training for mental health consultations. Participants for this study were pastors who served at least 5 years in one of the two unions. The two unions included in this study were the Atlantic Caribbean Union and the Jamaica Union, which includes the Bahamas Islands, Cayman Islands, Turks and Caicos Islands, and Jamaica.

Parishioners prefer consulting the clergy when faced with mental health issues for several reasons, which includes less stigma, low cost or free service, trust, cultural understandings, and easy accesses (Crosby & Bossley, 2012; Derr, 2016; Kirk, 2018; Leavey et al., 2017). However, several disadvantages may arise for both the parishioner and the clergy (Allen et al., 2010; Bilkins et al., 2016). Research has been conducted on various aspects of the clergy and their counseling habits, expectations, and limitations; however, previous researchers have focused on research data collected in the United States and the United Kingdom (Vernaas et al., 2017). Little is known about clergy in the Caribbean countries and how they conduct their parishioners' mental health consultations. In this final chapter, I summarize and interpret the findings. I also discuss the limitations of the study, recommendations for future research, and implications for positive social change.

Interpretation of the Findings

There were three themes that I determined from the first RQ: (a) recognizing mental health issues, (b) family issues are major concerns, and (c) strategies and decisions to refer. One major theme regarding pastor training emerged from the second RQ: (d) insufficiently trained. There was a total of 15 key topics derived from the findings. In the following sections, I discuss the themes and the key topics in relation to the literature I presented in Chapter 2.

Theme 1: Recognizing Mental Health Issues

Most pastors in this study said that they were able to recognize mental health issues. Each participant stated that they had their own way of recognizing mental health issues and these concerns came in various forms. The use of clergy for mental health consultations is so prominent that many researchers refer to them as gatekeepers for mental health treatment (Brown & McCreary, 2014; Kirk, 2018; Payne & Hays, 2016; VanderWaal et al., 2012). To deal with mental health issues, the clergy need to have the necessary competency to recognize mental health problems and address them or refer individuals to appropriate care (APA, 2020). Without proper training, the clergy will not be able to effectively address mental health and preserve their safety and the safety of their parishioners.

Results of this study are congruent with previous literature, indicating that many of the problems that the clergy responds to include grief and bereavement, medical concerns, marital and family conflicts, life stressors, and psychiatric disorders (Chatters et al., 2017; Mattis et al., 2007; Wang et al., 2003; Young et al., 2003). The pastors

recognized mental health issues through the following major indicators: (a) lack of coherence, (b) abnormal behaviour, (c) stress from family problems, and (d) depression.

Pastors in this study listened to their parishioners' consultations to help them; while listening, they observed the lack of coherence in their spoken thoughts and recognized that these are signs of mental health issues. Participants reported that the parishioners were not exhibiting other abnormal behaviour and, without speaking, the incoherence would have gone unnoticed. Many pastors reported that cognitive behaviour change was the most obvious cue they had that the person was suffering from mental health issues.

Pastors also recognized mental health issues through observing the abnormal behaviors of their parishioners. Having seen their members each week, they were able to recognize what was usual and what was unusual in their actions, personality, and emotions. Due to the relationship or leadership status of the pastor, he can approach the member to enquire of such abnormality, or other members may approach him with the concern. Some pastors reported recognizing mental health challenges in their members when they noticed abnormal behaviors.

Family life challenge is one of the most popular issues the pastors face in their ministry. These issues stress members, and in many cases lead to depression, anxiety, and general unhappiness. Many pastors who are untrained in psychology and counseling, cannot effectively handle family issues. Many pastors in this study stated that stress from family problems was how they recognized poor mental health in their congregations.

Because families comprise the congregations of churches, making the congregations equivalent to a big family (Činčala et al., 2021), it is understandable that the most frequent consultations are for family issues. Different families coming together to make a big church family result in misunderstandings and interpersonal problems.

Pastors often recognize signs of depression in their parishioners. Pastors in this study were familiar with their parishioners and recognize changes in their behaviors. Some of the congregants were mental health professionals, who could also spot this change in parishioners' behaviors. They may bring it to the pastor's attention, and he is able to approach the parishioner who is then helped through the pastor's referral to a mental health professional in his congregation. Other pastors in this study who were trained in psychology dealt with the parishioners' depression themselves. Pastors are, therefore, able to recognize many mental health problems and have encountered many cases in their ministry.

These findings were consistent with the literature, in which it was stated that in order to deal with mental health issues, the clergy would need to have the necessary competency to recognize mental health problems and address them or refer individuals to appropriate care (see APA, 2020). However, findings in other literature indicated that some pastors struggle to recognize certain mental health issues. For example, Heseltine-Carp and Hostings (2020) found that 72% of clergy felt that they were not sufficiently trained to recognize and manage mental health disorders. However, these clergy were effective at identifying serious mental health issues such as suicidal ideation, delusions, and substance misuse, but were not effective at recognizing depression, anxiety, or

obsessive-compulsive disorder. The depression, anxiety, and obsessive-compulsive disorder cases were not easily recognized by the pastors; therefore, parishioners were not referred to care and their issues were not addressed (Heseltine-Carp & Hoskins, 2020).

In contrast to Heseltine-Carp and Hoskins (2020), Payne (2014) conducted a study with 204 pastors in the California area from 26 denominations. Payne's goal was to have a discussion of the following statement: "The pastor is the best person to treat depression." Payne explored how both secularly educated or theologically educated pastors viewed intervening with depressed individuals. The level of the pastors' education did not change their belief that the pastor was the best person to treat depression neither did it change their view about referral to mental health professionals, which they preferred not to do.

The pastors of the Seventh-day Adventists Church in the Caribbean who were trained in psychology opted to treat the members with depression while those who lacked the training preferred to refer members to a psychiatric professional. In this study, I did not determine the quality and extension of the pastors' services compared to professional mental health services.

Theme 2: Family Issues are Major Concern

The second theme in this study was related to the reasons parishioners consult with pastors. The most relevant reason was family issues. The Seventh-day Adventist pastors stated that family issues were major challenges in the church. These challenges included marital issues, premarital preparation, and parenting. Based on participants' accounts, it can be inferred that people were also comfortable with their pastor, trusted

them, believed they had genuine concern for them, and consulted them to help with their family issues. Pastors were also approached by their parishioners because the church provides psychosocial resources and cultural similarity (Dalencour et al., 2017; Young et al., 2003). This cultural similarity is seen in the grouping of similar cultures in the Bahamas with a Spanish and a Haitian congregation, in the Cayman Islands with a Spanish and a Pilipino congregation, and in the Turk and Caicos Islands with Haitian congregations. In all these congregations, the native language is used, and the people are grouped with their own culture. This cultural matching improves mental health. Some of the psychosocial resources include helping members with food, health care, and financial support, and extra social support in cases of sickness, men's ministry, women's ministry, and children ministry (Office of Archive, 2017).

Challenges in marital relationships are a major concern for parishioners**.** Pastors in this study stated that they deal with issues related to marital relationships more often than any other issues. The Seventh-day Adventists Caribbean pastors spend a great portion of their ministry in premarital preparation. This is because issues arise in the marriages of the congregants in the church. The Seventh-day Adventist church strongly recommends that members seek premarital counseling before engagement (Oliver & Oliver, 2021). This is recommended before engagement so that the couple will pay more attention to any major issues before their wedding and so they can process the sessions with the objectivity needed to make the best-informed decision about a potential marriage partner (Oliver & Oliver, 2021).

Parenting is also a major concern in parishioners' families. Many pastors in this study spoke of parenting issues and stated that one of the parenting issues that they face is due to children experiencing upsetting content on social media or conflict in their homes and in their communities. The effect of experiencing upsetting content on social media and conflict at home is then manifested in their behaviors, which parents then seek to address with the mentoring help of their pastor. The children, such as the teens, often do not initiate help unless they are in serious trouble and often would prefer to conceal their trouble from their parents. Younger children with problems are different from adults with problems in that they may not be able to report what is happening to them depending on their age. However, untrained pastors do not have the skills to relate and elicit from them what is happening if they are not able to say it. In situations such as this, the assistance of a professional is required.

This theme is also consistent with the literature, including a study in which 39 pastors participated (Brown & McCreary, 2014). This study revealed that the pastors counseled their members concerning many and varied topics. However, more than 91% of those pastors reported that the predominant topics discussed were marriage and family problems. The incidence of other topics was reported as 87.5% spiritual problems, 79.2% bereavement, 78.8% job problems, among others (Brown & McCreary, 2014). That seems to confirm the continuing trend today that consultations on marriage challenges are the most frequently requested.

Finally, when the pastors engaged in addressing their parishioners' mental health concerns, they also engaged in dual relationships This placed the pastors in the position

of having to face the challenge of having dual relationships with their parishioners as they attend their parishioner's mental health issues. Multiple relationships in a professional setting can cause various problems and they may even harm the recipient of services (APA, 2017). While the pastors are not in a professional setting, they do exchange with their parishioners under different roles.

Theme 3: Strategies and Decisions to Refer

Each pastor extensively discussed the decision to refer, demonstrating that Seventh-day Adventist pastors are cognisant of the need to refer. All except one pastor said that they either refer as their first action once they identify the need for mental health services or when they realize that they are unable to help. The only pastor who said he did not refer was a trained pastor, and he believed he was prepared to handle all his parishioners' mental health issues.

Pastors affirmed that the Seventh-day Adventist church has many resources to handle parishioners' mental health issues. The pastors spoke of some Seventh-day Adventist Conferences that employ counselors as part of the staff to deal with the mental health issues; others said that they had mental health professionals in their congregation who helped them with their cases, while others used reputable outside sources to assist their parishioners.

The literature has suggested that pastors refer because they do not feel adequately prepared to handle counseling consultations. According to Cook and Wiley (2014), not all clergy are unwilling to refer their mental health cases, as indicated by a survey of over 200 clergies from more than 50 denominations (VanderWaal, 2012). In fact, almost 90%

indicated their willingness to allow a counselor into their church to do seminars and lead support groups. The participants in this research were Afro-Caribbean pastors, and they were known to be the leading consultants (see Eliason et al., 2013; Guo et al., 2011). In fact, Cook and Wiley (2014) said that African American clergy are the most used for parishioner consultations; therefore, they usually have a working list of resources for referral (Cook & Wiley, 2014; Eliason et al., 2013).

The literature has also suggested that pastors in general do not like sending their parishioners to outside professional sources unless it is to a Christian counselor (Bledsoe et al., 2013). The clergy also reported that they were more content when they knew that help with congregants was being undertaken by professionals who practice Christ-centered therapy, and they knew those professionals well and trusted their approach to mental health (Bledsoe et al., 2013). This is contrary to what the Seventh-day Adventist pastors in this study reported. Although the Seventh-day Adventist pastors had many resources in their church, they did not voice any fear when they found it necessary to use outside sources. Unlike pastors of other denomination, they did not seem very concerned about whether it was a Christian counselor. They seemed to be more secure about the faith of their parishioners in the context of the influence of the professionals who are not Christians.

Pastors reported working with God as the church is God's institution on earth. They described contacting God through prayer on anything on which they were embarking. Dealing with members' consultations was no different for them—they prayed. Some of the pastors were trained in psychology and they too believed they

needed God's guidance. They prayed to God for the competence to manifestly assist parishioners when these concerns may arise. Pastors of the Seventh-day Adventist Church pray with their members and seek God's guidance when addressing their concerns and issues, as they believe that all knowledge comes from God.

The literature showed that members use the pastor instead of the professionals due to the stigma that accompanies the visits to the mental health professionals. According to Bracke et al. (2017), stigma is defined as discrimination and hate and has been a barrier to seeking professional mental health care. It is one of the main reasons that parishioners seek help from the pastors as they believe it is less stigmatized as they may be talking to the pastor about anything, and some even make their approaches by asking for prayer, as seen in this research. Contrary to that, the literature has suggested that the clergy helps to stigmatize the persons with mental health illnesses (James et al., 2014). This stigmatization occurs in several forms, including (a) the use of prayer instead of medication for depressed members, (b) performing of exorcism, and (c) competing with traditional healers (Peteet, 2019). The very thing that the pastors of the Seventh-day Adventist pastors are doing to help their parishioner may be perceived as stigmatisation to others. While the Seventh-day Adventist pastors do not report the use of any of those three except prayer, they might be contributing to the stigmatization of their members.

Pastors reported that one of their strategies is to listen to their parishioners. Listening is a very basic but important skill in the helping profession. All a person may need is to be heard and release stifled emotions (Braillon & Taiebi, 2020). Pastors reported listening a lot to their clients in order to know what is needed to assist clients in

consultations. The literature supports the importance of listening in the therapeutic relationship. This basic micro-skill is what the pastors use for all their consultations. Such listening should be active and calls for a kind of listening that tries to understand the speakers' experience without judgment (Weger et al., 2010).

It is the pastor's sincere desire to help all parishioners who consult them. Unfortunately, pastors cannot help all parishioners as many of their consultations are for mental health problems that pastors are not equipped to address. The Seventh-day Adventists pastors are aware that they are not equipped to handle mental health consultations unless they are trained. Thus, all the participants discussed referring out and consulting to help their parishioners. The literature review confirms the stance of Seventh-day Adventist pastors. In their efforts to assist all their members, they sometimes recognize their own lack of competence. Pastors tend to have a working list of resources for referral (Cook & Riley, 2014). Today in the 21st century, with the fast growth of psychology and counseling, the clergy is still holding the role of gatekeeper of mental health (Brown & McCreary, 2014; Heseltine-Carp & Hoskins, 2020; Payne & Hays, 2016; VanderWaal et al. 2012). In a recent discussion of 35 pastors over a 13-day period, 140 comments were generated to the question: "If the church is where we are to come for healing, how do we handle people who are depressed, suicidal, suffering from PTSD or anxiety?'' The thematic analysis resulted in four characteristics common among the clergy. These include their personal experience with mental and emotional problems, the transparency in the stories they share, personal self-care, and their humility (Hayes,

2020). The Seventh-day Adventist Caribbean pastors genuinely want to help their parishioners and will do anything they can to help.

Theme 4: Insufficiently Trained

The second set of interview questions were centred around how the Seventh-day Adventist Caribbean pastors describe the training received to serve their parishioners' mental health consultations. Interestingly, half the pastors were trained to deal with mental health issue and half were not. The trained pastors took it on themselves to gain higher education to deal with mental health issues they face in ministry. They were all satisfied that they could help their parishioners even if it meant that they had to refer them for that help.

In this theme the pastors talked about what training they received that assisted them with the mental health consultations they encounter each day as they minister. According to them, their seminary is aware that they need the preparation and have included a course at each level of the theology degree journey, but that exposure was not sufficient adequate. Pastors believe that with the changes in the world today, it is inevitable that people's mental health will be affected. Some pastors believe that they are not mental health professionals and so the one course training received is enough to make them aware, help them recognize mental health challenges, and refer their parishioners. Then, there is another set of pastors who recognize the need for more training as they minister and have taken it upon themselves to do something about it, by finding the means to educate themselves professionally in mental health.

The literature confirms what the pastors are saying through the work of Josh S. Payne's (2013) research on the clergy's involvement in mental health. In his work, he found evidence that suggested that many members of the clergy lacked formal training in specific areas and do not consider themselves equipped to deal with mental health issues. Payne stated that training and education in mental health are what the clergy needs to be effective in helping with mental health issues (Payne, 2013). Because of the strategic location of the church and the high cost of mental health counseling that many people in the Caribbean cannot afford, the pastor has been recognized as the gatekeeper of mental health by many researchers. However, as the gatekeeper of mental health, or first responder, the clergy ought to be prepared to address mental health consultations (Heseltine-Carp & Hoskins, 2020; Payne, 2014; Payne, et al., 2016; Smetana, 2014).

Recognizing their inadequacy, several of these ministers have chosen to do their advance degrees in counseling, psychology, or chaplaincy. As shown in Table 1, located in chapter 4, all pastors except one held a master's degree and the one with the bachelor's degree was receiving training at a master's level at the time of the interview. This kind of qualification is very important to the counseling profession. In fact, the literature review points out the APA requirement for competence for mental health professionals. A lack of expertise in the area in which they are performing can hurt client and the therapist alike (American Counseling Association, 2015, APA, 2020).

Pastors extensively discussed the inefficiency of the one undergraduate course that the seminary offered. They did realize that seminary was not preparing them to be mental health professionals but for the pastoral ministry. However, given today's trends

in congregational needs for psychological counseling, they believe that there should be some changes in how they are prepared to assist parishioners in coping with and responding to mental health problems.

The standard set by the AAPC for clergy counseling is a bachelor's degree from an accredited university or college or seminary and a specialized masters or doctoral degree in the mental health field (AAPC, 2012; Payne, 2014; Roney, 2020). The literature has therefore confirmed that mental health specialization is necessary for pastors to assume responsibility for parishioners' mental health or to act as frontline personnel. The Seventh-day Adventist Caribbean pastors are indeed exercising due diligence in qualifying themselves for this challenge.

Among these are several pastors who are not trained in the mental health profession. In their experience in the field, they have seen the need for further training to deal with the volume of demand in their congregation for psychological consultations. A layer of complexity in referring to outside agencies relates to covering mental health expenses. Referrals must necessarily be undertaken with great reluctance, given that many parishioners do not have the necessary insurance or funds to pay for such services. Faced with such irreconcilable options, many parishioners expect the church to assist, an expectation which inevitably falls upon the pastor, who is already wearing many hats. Under the circumstances, these pastors do what they can to help (Hope et al., 2019; Leavey et al., 2017)

In an effort to assist parishioners, Seventh-day Adventist pastors admitted to consulting with individuals in higher echelons of the Adventist organization, seminary

counseling departments, mental health professionals within their congregations, and trained colleagues. These consultations give them ideas on how to address the consultations or to whom to make referrals. The pastors also admitted that seminars and workshops are sometimes provided to them. These resources provide valuable ideas on how to assist parishioners, even if it's just about identifying mental health issues, so they can be effectively referred.

The literature confirms that many pastors are aware of their inadequacies, a consciousness that is driven home in their experiences in attempting to assist parishioners (Brookings, 2022; Payne, 2013; Poole, 2017; Smietana, 2014). Indeed, a significant number of pastors have pursued higher education and qualifications in the mental health field, but there are some who have not, and it is this group that raises concern. An additional complexity is that despite their awareness of inadequacies, many seem to feel obligated to assist when parishioners initiate mental health consultations. Among the problems with that is the issue of boundary crossing which arises with various areas of violations (APA, 2017; Eliason et al., 2013; Guo, et al., 2011) including the duplication of pastoral and counseling roles, confidentiality, counseling competency, self-protection, and harm. The untrained pastors are not made aware of some of the ethical concerns that come with these sensitive boundary-crossing violations, trapping them at some points in unethical involvements with their clients. The precipitating reasons include that these issues have not been explored with them at the same level as it is taught to trained counselors. Without this training, pastors are at a clear disadvantage.

Interpretation of Findings in the Context of Social Exchange Theory

The conceptual framework used to ground this research is the social exchange theory. This theory purports that the parties in a relationship are motivated by the benefits the relationship is expected to bring (Blau, 1964; Cook et al., 2013; Wright, 2021). Thus, with an equitable valuable exchange, the clergy and the parishioners see this synergetic relationship considerably sustaining for both parties. Parishioners receive favorable benefits from the clergy and are satisfied with the outcome. The outcome is that parishioners are helped with their consultations; they do not have to pay; they do not need insurance; they trust their pastor, and there is no stigma attached to seeing him, which is quite the opposite when they see a mental health professional (Campbell & Littleton, 2018; Chevalier et al., 2015; Crosby & Bossley, 2012; Payne, 2008, 2014).

The clergy also benefits from taking care of the parishioners' consultations. Pastors often find that their congregants serve as their primary social support network. It's like a family that cares deeply about one another's well-being (Hough, 2019; McDonald, 2004). The clergy also report that they are quite content when they know that counseling support for congregants is carried out by mental health professionals who practice Christ-centered therapy, and they know those professionals well and trust their approach to mental health (Bledsoe, 2013).

The relationships among the participants, the clergy, and the parishioners are maintained as discussed through social exchange theory. This theory purports that the parties in a relationship are motivated by the benefits the relationship is expected to bring (Blau, 1964; Cook et al., 2013; Wright, 2021). As the pastor ministers, he is faced with

parishioners who have needs that include mental health needs. These needs are accompanied by the requirement to access services that are free or cost-effective, and have cultural understandings, less stigmatization, easy access, trust, and less suspicion—which are all consistent with the service the pastors provide. This is congruent with the social exchange theory—that parishioners benefit from the relationship. This synergetic relationship is maintained as the pastor benefits also (Blau, 1964; Cook et al., 2013; Wright, 2021).

According to the findings of this research, the pastors do all in their power to assist parishioners with their mental health consultations. They take higher education courses to qualify, they read widely, and they attend seminars and workshops. They also consult, pray, and refer when they realize they are unable to help. This is because they, too, want to maintain the relationship with their parishioners.

Indeed, pastors benefit from the relationship in several ways. They maintain their church membership; they protect their members, whom they regard as family; and they secure their financial support by way of tithing. At the same time, pastors report that they derive a great level of satisfaction just knowing that they are able to help their members.

Limitation of the Study

As I progressed through this study, I was faced with a few limitations that may have had great impact on this research. The first one is the restriction that COVID 19 imposed on my travel to do in-person interviews. Nevertheless, the Zoom interviews were just as effective—the participants seemed comfortable, and the interviews were still rich.

Another limitation may have been participants' interest in the subject. This may have been particularly so for the pastors responding to the invitation, as they may have responded because of their interest in mental health, and not from their perspective as pastors. This may have implications for deriving a real picture of the impact of Adventist pastor's knowledge, experience, and education concerning mental health. I say this because most the participants had training on mental health and those who were not trained were sensitive to the implications for their training deficiencies.

Another limitation may have been social desirability in which the participants may have been reluctant to discuss situations or cases in which they should have conferred or referred and did not. Additionally, being a member of the Seventh-day Adventist Church may have also elicited bias, although many strategies were exercised to reduce such personal biases. These strategies included, for example, peer reviews, committee feedback, and verifying responses with the participants when unsure of what was on the transcript.

Recommendations

The findings of this study will be useful in conversations of ministerial councils. The clergy is called the gateway to mental health by many and, as such, they should be informed concerning mental health. The Seventh-day Adventist Church is also the second largest church in the world with a membership of 21,912,161, served by 20,924 active pastors worldwide. The pastors should be studied to see what strategies they apply when addressing the mental health issues of the parishioners they encounter in their ministry on a daily basis.

In this study, pastors shared their experiences, and the analysis revealed gaps in current knowledge. This knowledge gap could motivate further research using qualitative methodology to explore the experiences of Seventh-day Adventist Church pastors in more depth. This research might include

- exploring the Seventh-day Adventist pastors' experience with their parishioners' mental health consultations with a larger less educated population,
- applying the study to a mixed sex group in the same denomination, or
- exploring with the pastoral seminary how best it could meet the needs of the pastors concerning mental health in their training.

Another line of research could target parishioners who received mental health services. Similarly, future research could explore the possible correlation between pastors' level of education and their willingness to participate in mental health research.

Implications

This research examined/studied/explored the Seventh-day Adventist Caribbean pastors' experiences in addressing their parishioners' mental health consultations and the training they received to do so. The results showed that pastors recognize mental health issues. The basic knowledge that the pastor has is enough to recognize the consultations that are mental health consultations. The literature maintains that the clergy population are gatekeepers of mental health services (Brown & McCreary, 2014; Heseltine-Carp & Hoskins, 2020; Payne & Hays 2016). It is hoped that this research will bring further awareness to pastors. It is also hoped that institutions that train pastors will see the

importance of giving their ministerial students more than the limited pastoral counseling courses currently envisaged for meeting the mental health needs of pastors' congregations.

The findings of this research indicate that pastors frequently encounter requests for consultation related to family issues during their ministry. Family problems often bring about stress and other mental health issues that are beyond the scope of pastors' training. With this understanding, this research may encourage changes in theological institutions, such as the addition of courses in marriage and family counseling. These adjustments to seminary courses would benefit congregations more broadly, as pastors could address family life concerns from the pulpit based on the issues they encounter in their consultations. Society as a whole could also benefit from this knowledge, as the government could leverage the newly inspired expertise among pastors to disseminate more family life information on radio and television.

While pastors do a significant amount of referring, their training in mental health issues may be insufficient unless they've pursued further education in the field. After all, as the findings indicate, the majority were trained in theology and not in the psychology field. Pastors may come to realize that referring is a valuable way to assist their congregations. Parishioners and, by extension, society will also recognize the importance of specific training for addressing mental health issues.

Although the literature maintains that the clergy are gatekeepers of mental health services, it is hoped that this research will bring further awareness to each pastor. It is hoped also that this awareness will include the serious harm that can occur if pastors try

to treat mental health consultations without adequate competency. It is hoped that pastors may be inspired to seek sufficient knowledge to recognize the difference between a non-psychotropic issue and a mental health problem and to utilize the appropriate resources to help their parishioners.

One of the findings of this research, given that pastors most frequently encounter requests for consultations related to family issues, is the potential benefits that can result from the pastor's intimate knowledge of their congregation's needs. This knowledge should enhance their planning of church activities, sermon presentations, and interactions with congregants. This knowledge will also help the church leadership to bring in specialist to educate that congregants on these issues that are more prevalent. The government and other service organizations can also be utilized to create programs that will benefit members in those areas of concern. Through these various initiatives, both the congregation and the broader society can benefit. Pastors can use the knowledge gained from this research to better prepare themselves to assist their parishioners, either by acquiring the necessary competence or making appropriate referrals. This research should also encourage them to seek the best referral options in cases where they are unable to provide direct assistance.

Conclusion

Seventh-day Adventist Caribbean pastors, though primarily trained for religious ministry, are increasingly being sought out to assist with mental health issues. While many pastors have pursued additional training, a significant number have received minimal education in psychology, typically limited to a single course offered at each

level of their ministerial training and education. Despite this, they are often bestowed with the title of "gatekeeper of mental health" by many, with all the responsibilities that such a title implies. Of particular concern are those pastors who lack formal training yet have readily available clientele in their congregations and communities. These individuals believe that their pastors are capable of addressing their mental health issues and often seek their help.

It is important for both the clergy and the members to recognize the distinction between a pastor and a mental health professional, or a pastor trained to address mental health issues versus one solely trained for pastoral ministry. When both parties fully understand these differences, both pastors and members will be better served. To advance this crucial objective, this chapter will cover the interpretation of findings, limitations, recommendations, implications, and the conclusion of this research. It is our hope that these findings will initiate discussions on seminary training and prompt policy changes within the higher organizational levels of the Seventh-day Adventist Church.

References

AAPC. (2012). What is pastoral counseling? (The American Association of Pastoral Counselors) http://aapc.org/content/what-pastoral-counseling

Abe-Kim, J., Takeuchi, D. T., Hong, S. (2007). Use of mental health-related services among immigrant and US-born Asian Americans: Results from the National Latino and Asian American Study. *American Journal of Public Health. 97,* 91–98. https://doi.org/10.2105/ajph.2006.098541

Abu-Alhaija, A. S. (2019). From epistemology to structural equation modeling: An essential guide in understanding the principles of research philosophy in selecting the appropriate methodology. *Australian Journal of Basic and Applied Sciences, 13*(9), 122-128. https://doi.org/10.22587/ajbas.2019.13.9.12

Allen, A. J., Davey, M. P., & Davey, A. (2010). Being examples to the flock: The role of church leaders and African American families seeking mental health care services. *Contemporary Family Therapy, 32*, 117 - 134. https://doi.org/10.1007/s10591-009-9108-4

American Association of Pastoral Counselors. (2012). *What is pastoral counseling*. http://aapc.org/content/what-pastoral-counseling

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct (2002, amended effective June 1, 2010, and January 1, 2017)*. https://www.apa.org/ethics/code/

American Psychological Association. (2020). Publication Manual of the American Psychological Association, (2020). American Psychological Association, 428.

https://doi.org/10.3916/school-of-authors-100

American Counseling Association. (2015). *2014 ACA code of ethics*. https://www.counseling.org/docs/default-source/default-document-library/2014-code-of-ethics-finaladdress.pdf. https://doi.org/10.1002/9781119221555.part1

Amin, M. E. K., Nørgaard, L. S., Cavaco, A. M., Witry, M. J., Hillman, L., Cernasev, A., & Desselle, S. P. (2020). Establishing trustworthiness and authenticity in qualitative pharmacy research. *Research in Social and Administrative Pharmacy, 16*(10), 1472-1482. https://doi.org/10.1016/j.sapharm.2020.02.005

Assmann, J., Bernstein, R., Goetschel, W., Hendel, R., Malabou, C., Schwab, G., ... & Whitebook, J. (2018). *Freud and monotheism: Moses and the violent origins of religion*. Fordham Univ Press. https://doi.org/10.2307/j.ctt1xzh109.9

Aten, J. D., Boan, D. M., Hosey, J. M., Topping, S.; Graham, A., & Im, H. (2013). Building capacity for responding to disaster emotional and spiritual needs. A clergy, academic, and mental health partnership model (CAMP). *Psychological Trauma: Theory, Research, Practice, and Policy*, *5*, 591-600. https://doi.org/10.1037,2014,925359

Avent, J., Cashwell, C. S., & Brown-Jeffy, S. (2015). African American pastors on mental health, coping, and help-seeking. *Counseling and Values, 60*, 32-47.

Ayvaci, E. R. (2016). Religious barriers to mental healthcare. *American Journal of Psychiatry Residents' Journal* 2016 11(7), 11-13. https://doi.org/10.1002/j.2161-007x.2015.00059.x

Banta, J., Lee, J., Hodgkin, G., Yi, Z., Fanica, A., & Sabate, J. (2018). The global

influence of the Seventh-Day Adventist Church on fiet. *Religions*, *9*(9), 251. https://doi.org/10.3390/rel9090251

Barnett, J. E. & Johnson, W. B. (2011) Integrating spirituality and religion into psychotherapy: Persistent dilemmas, ethical issues, and a proposed decision-making process, *Ethics & Behavior, 21*(2), 147-164. https://doi.org/10.1080/10508422.2011.551471

Bekhet, A. K. &Zauszniewski, J. A. (2012). Ethodological triangulation: An Approach to understanding data. Nurse Researcher, 20(2), 40-43. Retrieved from http://www.nurse-standard.co.uk

Bender, D. S., Skodol, A. E., Dyck, I. R., Markowitz, J. C., Shea M. T., Yen, S., Sanislow, C. A., McGlashan, T. H., Gunderson, J. G., Daversa, M. T., &Grilo, C. M. (2007). Ethnicity and mental health treatment utilization by patients with personality disorders, Journal of Consulting and Clinical Psychology, 75(6), 992-999. https://doi.org/10.1037/0022-006X.75.6.992

Benjamin Jr, L. T. (2023). *A brief history of modern psychology*. John Wiley & Sons.

Biggerstaff, D. L. & Thompson, A. R. (2008). Qualitative Research in Psychology5: 173 –183. https://doi.org/10.1080/14780880802314304

Bitsch, V. (2005). Qualitative research: A grounded theory example and evaluation criteria. *Journal of Agribusiness*, 23(1), 75-91.

Bilkins, B., Allen, A., Davey, M. P., & Davey, A. (2016). Black church leaders' attitudes about mental health services: Role of racial discrimination. *Contemporary Family Therapy: An International Journal, 38*(2), 184–197.

https://doi.org/10.1007/s10591-015-9363-5

Blau, P. M., (1964). Exchange and Power in Social Life. Wiley, New York. https://doi.org/10.4324/9780203792643

Bledsoe, S., & Adams, C. (2011). Promoting emotional well-being among southern California parishioners through clergy/mental health practitioner collaboration. Paper presented at the North American Association of Christians in Social Work Annual Convention, Pittsburgh, PA.

Bledsoe, T. S., Setterland, K., Adams, C., J., Folk-Trela, A., & Connolly, M. (2013). Social Work & Christianity. *Journal of the North American Association of Christians in Social Work.* Vol. 40, No. 1(2013), 23-45

Bonner, L. M., Lanto, A. B., Bolkan, C., Watson, G. S., Campbell, D. G., Chaney, E. F., Rubenstein, L. V. (2013). Help-seeking from clergy and spiritual counselors among veterans with depression and PTSD in primary care. *Journal of Religion and Health.* Advanced online publication. https://doi.org/10.1007/s10943-012-9671-0

Boorstein, M. (2015). Seventh-day Adventists vote against female ordination. The Washington Post, Social Issues. https://www.washingtonpost.com/local/social-issues/seventh-day-adventists-vote-against-female-ordination/2015/07/08/42920f7e-25c8-11e5-b77f-eb13a215f593_story.html

Bowen, G. A. (2009). Document analysis as a qualitative research method. Qualitative Research Journal, 9(2), 27-40. https://doi.org/10.3316/qrj0902027

Bracke, P., Delaruelle, K. & Verhaeghe, M. (2017). Dominant Cultural and Personal

Stigma Beliefs and the Utilization of Mental Health Services: A Cross-National Comparison, Department of Sociology, Ghent University, Ghent, Belgium. https://doi.org/10.3389/fsoc.2019.00040

Braillon, A., & Taiebi, F. (2020). Practicing "reflective listening" is a mandatory prerequisite for empathy. Patient education and counseling, 103(9), 1866-1867. https://doi.org/10.1016/j.pec.2020.03.024

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? International Journal of Qualitative Studies on Health and Well-Being, 9, 1–2. https://doi.org/10.3402/qhw.v9.26152

Braun, V., & Clarke, V. (2021). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. Qualitative research in sport, exercise and health, 13(2), 201-216. https://doi.org/10.1080/2159676x.2019.1704846

Brookins, A. D. (2022). The Lived Experiences of Black Pastors Who Counsel the Black Community (Doctoral dissertation, Northcentral University).

Brown, J. Y. & McCreary, M. L. (2014). Pastors' counseling practices and perceptions of mental health services: Implications for African American mental health. *Journal of Pastoral Care & Counseling.* 68(1), 1-14. https://doi.org/10.1177/154230501406800102

Bumgardner, L. H. (2015). Adventist women clergy: their call and experiences. *Journal of Applied Christian Leadership*, *9*(2), 40-53. https://doi.org/10.32597/dissertations/252/

Campbell, A. D. (2021). Clergy Perceptions of Mental Illness and Confronting Stigma in Congregations. *Religions, 12*(12), 1110. https://doi.org/10.3390/rel12121110

Campbell, R. D. & Littleton, T. (2018). Mental Health Counselling in the Black American Church: Reflections and recommendation from counsellors serving in a counselling ministry. *Mental Health, Religion & Culture, 21*:4; 336-352, https://doi.org/10.1080/13674676.2018.1494704

Capps, D. (1993). Sex in the parish: Social -scientific explanations for why it occurs. *The Journal of Pastoral Care 47*(4), 350-361. https://doi.org/10.1177/002234099304700403

Carsello, R. (2022). What Influences Parishioner Attendance at Church? (Doctoral dissertation, Saint Leo University).

Carter, N.; Bryant-Lukosius, D.; DiCenso, A.; Blythe, J.; Neville, A. J. (2014). The Use of Triangulation in Qualitative Research. *Oncology Nursing Forum*. Sep.2014, Vol. 41 Issue 5, p545-547. 3p. https://doi.org/10.1188/14.onf.545-547

Chan, G. C. K., Leung, J., Quinn, C., et al., (2016). Rural and urban differences in adolescent alcohol use, alcohol supply, and parental drinking. J Rural Health 2016; 32:280–6. 10.1111/jrh.12151. https://doi.org/10.1111/jrh.12151

Chatters, L. M., Taylor, R. J., Woodward, A. T., Bohnert, A. S., Peterson, T. L., & Perron, B. E. (2017). Differences between African Americans and non-Hispanic Whites utilization of clergy for counseling with serious personal problems. *Race and Social Problems*, *9*, 139-149. https://doi.org/10.1007/s12552-017-9207-z

Chevalier, L., Godfarb, E., Miller, J., Hoeppner, B., Corrindo, T., &Birnmaum, R. J.

(2015). Gaps in preparedness of clergy and healthcare providers to address mental health needs of returning service members. *Journal of Religion and Health*, 54, 327-338. https://doi.org/10.1007/s10943-014-9917-0

Činčala, P., Drumm, R. D., Sahlin, M., & Sauceda, A. (2021). A Look at the Seventh-day Adventist Church: Unique or Only "Different?". Theology Today, 78(3), 236-249. https://doi.org/10.1177/00405736211030231

Cohen, L., Manion, L., & Morrison, K. (2011). Research Methods in Education (7th ed.). London: Routledge. https://doi.org/10.4324/9781315456539

Compton-Lilly, C. (2014). The development of writing habitus: A ten-year case study of a young writer. *Written Communication*, *31*(4), 371-403. https://doi.org/10.1177/0741088314549539

Cook, D.A. & Wiley, C.Y. (2014). Psychotherapy with members of African American churches and spiritual traditions. In P. S. Richards & A. E. Bergin (eds.) *Handbook of Psychotherapy and Religious Diversity* (2nd ed.), (pp. 373-397). Washington, DC: APA Books. https://doi.org/10.1037/14371-015

Cook, K. S., Hahn, M., Abrutyn, S., & McCaffree, K. (2021). Social exchange theory: current status and future directions. *Theoretical sociology: The future of a disciplinary foundation*, 179-205. https://doi.org/10.4324/9781003141372-14

Cook, K. S., Cheshire, C., Rice, E. R., & Nakagawa, S. (2013). Social Exchange Theory. In Handbook of Social Psychology (pp. 61-88). Dordrecht: Springer. https://doi.org/10.1007/978-94-007-6772-0_3

Courtois, C. A., & Steinberg, A. (L.). (2021). Sexual boundary violations in pastoral

counseling. In A. (L.) Steinberg, J. L. Alpert, & C. A. Courtois (Eds.), Sexual boundary violations in psychotherapy: Facing therapist indiscretions, transgressions, and misconduct (pp. 157–183). American Psychological Association. https://doi.org/10.1037/0000247-010

Creswell, J. W. (2017). Qualitative Inquiry & Research Design, Choosing Among Five Approaches. (4thEd.) Sage Publication Inc. https://doi.org/10.13187/rjs.2017.1.30

Creswell, J. W., & Creswell, J. D. (2017). Research design: Qualitative, quantitative, and mixed methods approaches. Sage publications

Crosby, J. W., & Bossley, N. (2012). The religiosity gap: Preferences for seeking help from religious advisors. *Mental Health, Religion, & Culture*, 15(2), 141–219. https://doi.org/10.1080/13674676.2011.561485

Cuthbertson, L. M., Robb, Y. A., & Blair, S. (2020). Theory and application of research principles and philosophical underpinning for a study utilising interpretative phenomenological analysis. Radiography, 26(2), e94-e102. https://doi.org/10.1016/j.radi.2019.11.092

Dalencour, M., Wong, E. C., Tang, L., Dixon, E., Lucas-Wright, A., Wells, K., & Miranda, J. (2017). The role of faith-based organizations in the depression care of African Americans and Hispanics in Los Angeles. Psychiatric Services, 68(4), 368-374. https://doi.org/10.1176/appi.ps.201500318

Daniel, B. K. (2019, June). What constitutes a good qualitative research study? Fundamental dimensions and indicators of rigour in qualitative research: The TACT framework. In *Proceedings of the European conference of research*

methods for business & management studies (pp. 101-108). https://doi.org/10.34190/rm.19.113

Derr, A. S. (2016). Mental health service use among immigrants in the United States: A systematic review. *Psychiatric Services (Washington, D.C.), 67*(3), 265–274. http://doi.org/10.1176/appi.ps.201500004.

Dobrin, A. (2002). Secrets and Pastoral Counseling: A Personal View. International Journal of Philosophical Practice, 1(3), 80-88. https://doi.org/10.5840/ijpp20021310

Dudley, R. L. (1996). How Seventh-day Adventist lay members view women pastors. Review of Religious Research, 133-141. https://doi.org/10.2307/3512337

Dupree, L. W., Watson, M. A., & Schneider, M. G. (2005). Preferences for mental health care: a comparison of older African Americans and older Caucasians. *Journal of Applied Gerontology,* 24(3), 196-210. https://doi.org/10.1177/0733464804272100

Eddy, D. M., Hollingworth, W., Caro, J. J., Tsevat, J., McDonald, K. M., Wong, J. B. (2012). Model Transparency and Validation: A Report of the ISPOR-SMDM Modeling Good Research Practices Task Force–7. ISPOR-SMDM Modeling Good Research Practices Task Force. Tufts University School of Medicine, Boston, MA (JW). https://doi.org/10.1016/j.jval.2012.04.012

Eliason, G. T., Lepore, M. & Homes, D. (2013). Ethics in pastoral care and counseling: A contemporary review of updated standards in the field. *Journal of Pastoral Care & Counseling.*, 67(2), 1-11. https://doi.org/10.1177/154230501306700203

Emerson, R. M. (1976). Social Exchange Theory. Annual Review Inc.

https://doi.org/10.2307/3512337

Eproson Jr, C. W. (2021). *Pastor Preparation to Support Congregants with Mental Health Issues: A Qualitative Descriptive Study* (Doctoral dissertation, Grand Canyon University).

Exline, J. J., Pargament, K. I., Wilt, J. A., & Harriott, V. A. (2021). Mental illness, normal psychological processes, or attacks by the devil? Three lenses to frame demonic struggles in therapy. *Spirituality in Clinical Practice*, *8*(3), 215–228. https://doi.org/10.1037/scp0000268

Farrell, J. L. & Goebert, D. A. (2008). Collaboration Between psychiatrists and clergy in recognizing and treating serious mental illness. https://doi.org/10.1176/ps.2008.59.4.437

Farshadnia, E., Memaryan, N., Asgharnejad Farid, A. A., & Bolhari, J. (2018). Who Can Provide Spiritual Counseling? A Qualitative Study from Iran. Indian journal of palliative care, 24(4), 517–525. https://doi.org/10.4103/IJPC.IJPC_104_18

Fisher, C. B. (2021). *Decoding the ethics code: A practical guide for psychologists*. Sage Publications.

Francis, L., Laycock, P., & Brewster, C. (2017). Work-related psychological wellbeing: Testing the balanced affect model among Anglican clergy. Religions, 8(7), 118. https://doi.org/10.3390/rel8070118

Friedman, E. C. (2020). Psychotherapist and Wiccan Clergy: The ethics of a dual relationship. Pomegranate, 16-25. https://doi.org/10.1558/pome.v13i10.16

Fulford, K. W. M., & Jackson, M. (1997). Spiritual experience and psychopathology.

Philosophy, Psychiatry, & Psychology, 4(1), 41-65.

Fulford, K. W. M. (2018) Religion and psychiatry: Extending the limits of tolerance. In *Psychiatry and Religion* (pp. 5-22). Routledge. https://doi.org/10.4324/9780429490576-2

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitiave Report*, 20(9), 1408. https://doi.org/10.46743/2160-3715/2015.2281

Galanis, Petros (2018). Data analysis in qualitative research: Thematic analysis. *Archives of Hellenic Medicine* 35(3):416-421.Gamwell and Tomes, (1995). Madness in America: Cultural University Press, New York, NY, USA.

Galderisi, S., Heinz, A., Kastrup, M., Beezhold, J., & Sartorius, N. (2015). Toward a new definition of mental health. *World psychiatry*, *14*(2), 231. https://doi.org/10.1002/wps.20231

Gamwell, L., & Tomes, N. (1995). Madness in America: Cultural and medical perceptions of mental illness before 1914. (No Title). https://doi.org/10.1086/357642

Garland, D. R.; Argueta, C. (2010). How Clergy Sexual Misconduct Happens: A Qualitative Study of First-Hand Accounts. *Social Work & Christianity.* Spring 2010, Vol. 37 Issue 1, p1-27. 27p.

General Conference of Seventh-day Adventists. Premarital Guidance in the Seventh-day Adventist Church. chttps://family.adventist.org/people/couples/premarital-guidance-in-seventh-day-adventist-church/

General Conference of Seventh-day Adventists (2015). 28 Fundamental Beliefs, 2015th Edition. www.adventist.org.https://szu.adventist.org/wp-content/uploads/2016/04/28_Beliefs.pdf

Gluck, S. (2015, January 15). What Is Stigma? Healthy Place. Retrieved on 2019, July 9 from https://www.healthyplace.com/stigma/stand-up-for-mental-health/what-is-stigma

Gonzalez, J. M., Alegria, M., Prihoda, T. J., Copeland, L. A., & Zeber, J. E. (2011). How the relationship of attitudes toward mental health treatment and service use differs by age, gender, ethnicity/race and education, *Social Psychiatry and Psychiatric Epistemology*, 46, 45-57. https://doi.org/10.1007/s00127-009-0168-4

Greenidge, W. L., Daire, A. P., & Lewis, S. (2011). The role of outcome expectations, social stigma, and perceived social support in the attitudes towards seeking counseling of Caribbean clients. In Ideas and Research you can use: VISTAS 2011. Retrieved from https://www.counseling.org/resources/library/vistas/2011-V-Online/Article_74.pdf

Griffith, E. E. H. & Young, J. L. (2004). Clergy Counselors and Confidentiality: A Case for Scrutiny. *The journal of the American Academy of Psychiatry and the Law*. Volume 32, Number 1, 2004·

Guo, Y. J., Wang, & S. -C., Johnson, V. (2011). Teach ethical and legal issues in counseling: A model to enhance students' le1037/emharning. Retrieved from http://counselingoutfitters.com/vistas/vistas11/Article_31.pdf.

Hall, S. A., & Gjesfjeld, C. D. (2013). Clergy: A partner in rural mental health? *Journal*

of Rural Mental Health, 37(1), 50-57. https://Doi:10.1037/0022-0167.52.2.146

Harris, Jasmine, "African American Pentecostal Clergy Members' Perceptions Of Mental Health and Their Subsequent Referral Practices" (2018). PCOM Psychology Dissertations. 460. https://digitalcommons.pcom.edu/psychology_dissertations/460

Hays, K., & Lincoln, K. D. (2017). Mental health help-seeking profiles among African Americans: Exploring the influence of religion. Race and Social Problems, 9(2), 127-138. https://doi.org/10.1007/s12552-017-9193-1

Hays, K., & Shepard Payne, J. (2020). Lived experience, transparency, help, and humility: Four characteristics of clergy responding to mental and emotional problems. Journal of Pastoral Care & Counseling, 74(1), 4-11. https://doi.org/10.1007/s12552-017-9193-1

Heck, A., Drumm, R., McBride, D., & Sedlacek, D. (2018). Seventh-day Adventist clergy: Understanding stressors and coping mechanisms. *Review of Religious Research*, *60*(1), 115-132. https://doi.org/10.1007/s13644-017-0312-7 doi:http://dx.doi.org.ezp.waldenulibrary.org/10.1007/s13644-017-0312-7

Hirsch, J. K., Nsamenang, S. A., Chang, E. C., & Kaslow, N. J. (2014). Spiritual well-being and depressive symptoms in female African American suicide attempters: Mediating effects of optimism and pessimism. *Psychology of Religion and Spirituality*, *6*(4), 276. https://doi.org/10.1037/a0036723

Heseltine-Carp, W., & Hoskins, M. (2020). Clergy as a frontline mental health service: a UK survey of medical practitioners and clergy. *General psychiatry*, *33*(6),

e100229. https://doi.org/10.1136/gpsych-2020-100229

Hibbert, B. C. (2023). *To Investigate the Impact that the Absence of a Counseling Training Program for Pastors and Ministers at the Church of Jesus Christ (Apostolic), Inc.(CJCA) Has on Their Job Satisfaction, Frustration Levels, and Self-Efficacy* (Doctoral dissertation, New Brunswick Theological Seminary).

Holt, A. (2010). Using the telephone for narrative interviewing: a research note. *Qualitative Research*, 10(1), 113-121. https://doi.org/10.1177/1468794109348686

Homans, G. C. (1974) Social Behaviour: Its Elementary Forms. Rev. ed. New York: Harcourt Brace Jovanovich, Inc. https://doi.org/10.1093/sf/54.2.474

Hope, M. O., Taylor, R. J., Nguyen, A. W., & Chatters, L. M. (2019). Church support among African American and Black Caribbean adolescents. Journal of child and family studies, 28(11), 3037-3050. https://doi.org/10.1007/s10826-019-01479-5

Hough, H., Proeschold-Bell, R. J., Liu, X., Weisner, C., Turner, E. L., & Yao, J. (2019). Relationships between Sabbath observance and mental, physical, and spiritual health in clergy. Pastoral Psychology, 68(2), 171-193. https://doi.org/10.1007/s11089-018-0838-9

Hunter, W. & Stanford, M. (2014). Adolescent mental health: the role of youth and college pastors. *Mental Health, Religion & Culture*, 2014, Vol. 17, No. 10, 957–966, http://dx.doi.org/10.1080/13674676.2014.966663

Hutchinson, G., & Rose, J. (2010). The development of clinical psychology in Trinidad at Psychology forum, 215, 40-42. https://doi.org/10.53841/bpscpf.2011.1.215.40

Iheanacho, T., Stefanovics, E. & Ezeanolue, E.E. Clergy's Beliefs About Mental Illness

and Their Perception of Its Treatability: Experience from a Church-Based Prevention of Mother-to-Child HIV Transmission (PMTCT) Trial in Nigeria. J Relig Health 57, 1483–1496 (2018). https://doi.org/10.1007/s10943-017-0545-3

Irakoze, P. (2021). A program to promote spirituality in family life in the Jabe Seventh-Day Adventist Church in Bujumbura District (Doctoral dissertation, Adventist University of Africa, Theological Seminary).

James, B. O., Igbinomwanhia, N. G., & Omoaregba, J. O. (2014). Clergy as collaborators in the delivery of mental health care: An exploratory survey from Benin City, Nigeria. *Tranascultural psychiatry*, 51, 569-580, https://doi:10.1177/1363461514525219

Jones, J. M. (2021). US church membership falls below majority for first time. *Gallup News*. https://news.gallup.com/poll/341963/church-membership-falls-below-majority-first-time.aspx

Jones, D. L., Cassidy, L. & Heflinger, C. A. (2012). "You can talk to them. You can pray": Rural Clergy Responses to Adolescents with Mental Health Concerns. *Journal of Rural Mental Health,* 36, 24-33, https://doi.org/10.1037/h0094777

Jordan, T. (2020). Combatting Stigma and Shame Associated with Professional Mental Health Help-Seeking Attitudes in the African American Community: An Inquiry with African American Pastors (Doctoral dissertation, Nova Southeastern University).

Jorm, A. F. (2012). Mental Health Literacy; Empowering the community to take action for better mental health, American Psychologist, 67, 231-243.

https://doi.org/10.1037/a0025957

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, R., & Pollitt, P. (1997). "Mental health literacy": A survey of the public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment. Medical *Journal of Australia*, 166, 182-186. https://doi.org/10.5694/j.1326-5377.1997.tb140071.x

Josephson, A., & Peteet, J. (Eds), (2004). *Handbook of Spirituality and worldview in clinical practice.* Washington, D.C.; American Psychiatric Publishing Inc. https://doi.org/10.1192/pb.29.9.357-a

Justice, J. A., & Garland, D. R. (2010). Dual relationships in congregational practice: ethical guidelines for congregational social workers and pastors. Social Work and Christianity, 37, 437–445.

Kallio, H., Pietala, A. M. & kangasniemi, M. (2016). Systematic method review: developing a framework for a qualitative semi-structured interview guide. *Journal of Advance Nursing*, 72(12), 2954-2965. https://doi.org/10.1111/jan.13031

KANG, E., & Hwang, H. J. (2021). Ethical conducts in qualitative research methodology: Participant observation and interview process. Journal of Research and Publication Ethics, 2(2), 5-10.

Kawaii-Bogue, B., Williams, N. J., & MacNear, K. (2017). Mental health care access and treatment utilization in African American communities: An integrative care framework. Best Practices in Mental Health, 13(2), 11-29.

Kehoe, N. C., & Dell, M. L. (2021). Clergy-Clinician Collaboration. In Christianity and Psychiatry (pp. 217-230). Springer, Cham. https://doi.org/10.1007/978-3-030-80854-9_15

Kirk, K. (2018). "Religious Advisors' Mental Illness Stigma: Pentecostal Attributions". *Doctoral Dissertations and Projects*. 1719. https://digitalcommons.liberty.edu/doctoral/1719

Koenig, H. G., George, L. K. & Titus, P. (2004). Religion, spirituality, and health in medically ill hospitalized older patients. *Journal of American Geriatrics Society*, 52(4), 554-562. https://doi.org/10.1111/j.1532-5415.2004.52161.x

Koenig, H. G., King, D. E., and Carson, V. B. (2012). *Handbook of Religion and Health*, Oxford University Press, New York, NY, USA, 2nd edition, 2012.

Koeppe, K. (2014). Attitudes and Beliefs of Seventh-day Adventists Concerning Psychology, Counseling, and Mental Health Issues. Andrews University. Dissertations, 496. https://doi.org/10.32597/dissertations/496/

Krippendorff, K., 2004. Content analysis: an introduction to its methodology. Sage Publications Ltd. London. https://doi.org/10.4135/9781071878781

Kvale, S., & Brinkmann, S. (2009). Interviews: Learning the Craft of Qualitative Research Interviewing. Los Angeles, CA: Sage.

Landerer, F. W., Flechtner, F. M., Save, H., Webb, F. H., Bandikova, T., Bertiger, W. I., ... & Yuan, D. N. (2020). Extending the global mass change data record: GRACE Follow-On instrument and science data performance. Geophysical Research Letters, 47(12), e2020GL088306. https://doi.org/10.1029/2020gl088306

Larkin, M., & Thompson, A. R. (2012). Interpretative phenomenological analysis in mental health and psychotherapy research. *Qualitative research methods in mental health and psychotherapy*, 101-116. https://doi.org/10.1002/9781119973249.ch8

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

Leavey, G., Loewenthal, K., & King, M. (2017). Pastoral Care of Mental Illness and the accommodation of African Christian beliefs and practices by UK clergy. *Transcultural Psychiatry* 2017. Vol. 54(1) 86-106. https://doi.org/10.1177/1363461516689016

Leighton, K., Kardong-Edgren, S., Schneidereith, T., & Foisy-Doll, C. (2021). Using social media and snowball sampling as an alternative recruitment strategy for research. *Clinical simulation in nursing*, *55*, 37-42. https://doi.org/10.1016/j.ecns.2021.03.006

Levinger, G. (1976). A Social Psychological Perspective on Marital Dissolution, *Journal of Social Issues,* 32 (1): 21–47, doi: https://doi.org/10.1111/j.1540-4560.1976.tb02478.x

Li, A. W., & Hebert, M. (2023). Unpacking an online peer-mediated and self-reflective revision process in second-language persuasive writing. Reading and Writing, 1-29. https://doi.org/10.1007/s11145-023-10466-8

Livingston J. D., Boyd J (2010) Correlates and consequences of internalized stigma for

people living with mental illness: A systematic review and meta-analysis. *Social Science and Medicine*; 7: 2150-2161. https://doi.org/10.1016/j.socscimed.2010.09.030

Logan, J. R., Deane, G. (2003). *Black diversity in metropolitan America*. Retrieved June 1, 2006, from http://mumford1.dyndns.org/cen2000/BlackWhite/BlackDiversityReport/black-diversity01.htm.Google Scholar

Letuka, V. S. (2020). Power Abuse by Church Leaders: A Case Study, University of Pretoria: Research Output, http://hdl.handle.net/2263/78463

Macnee, L. C., & McCabe, S. (2008). Understanding nursing research: Using research evidence-based practice. Philadelphia, PA: Lippincott Williams & Wilkins.

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum: Qualitative Social Research, 11*(3). Retrieved from file:///C:/Documents%20and%20Settings/Owner/My%20Documents/Pat/NCU/Di sser tation%20Proposal/Mason%20saturation%20article.htm

Masuda, A., Anderson, P. L., Twohig, M. P., Feinstein, A. B., Chou, Y., Wendell, J. W., Stormo, A. R. (2009). Help-seeking experiences and attitudes among africanamerican, asianamerican, and europeanamerican college students, *International Journal for the Advancement of Counseling*, 31, 168-180. https://doi.org/10.1007/s10447-009-9076-2

Mattis, J. S., Mitchell, N., Zapata, A., Garyman, N., Taylor, R. J., Chatters, L. M., et al. (2007). Uses of ministerial support by African Americans: A focus group study.

American Journal of Orthopsychiatry, 77(2), 249-258. https://doi.org/10.1037/0002-9432.77.2.249

Matusitz, J. O. (2015). How Dark a World It Is … Where Mental Health Is Poorly Treated": Mental Illness Frames in Sermons Given After the Sandy Hook Shootings. *Health Communication*, 31(12), 1-9. https://doi.org/10.1080/10410236.2015.1089458

Maxwell, J. A. (2012). Qualitative research design: An interactive approach (vol. 41). Sage publications.

McDonald, B. R. (2004). A qualitative study of clergy career satisfaction, functioning, and clergy-congregant relations. The College of William and Mary.

McLeod, J. O. H. N., Stiles, W. B., & Levitt, H. (2021). Qualitative research: Contributions to psychotherapy practice, theory and policy. *Bergin & Garfield's Handbook of Psychotherapy and Behavior Change*.

Mead, M. (2009). *Empire Windrush*: The cultural memory of an imaginary arrival, *Journal of Postcolonial Writing*, 45:2, 137-149, https://doi.org/10.1080/17449850902819920

Mental Health: A Report of the Surgeon General. Rockville, Md: US Department of Health and Human Services, US 1999. https://doi.org/10.1037/e435532005-001

Merriam, S. B. (2014). Qualitative Research: A guide to design and implementation. John Wiley and Sons.

Meyer, K., & Willis, R. (2019). Looking back to move forward: The value of reflexive journaling for novice researchers. Journal of gerontological social work, 62(5),

578-585. https://doi.org/10.1080/01634372.2018.1559906

Milstein, G., Meniere, A., Susman, V., & Bruce, M. L. (2008). Implementation of a program to improve the continuity of mental health care through clergy outreach and professional engagement (COPE). *Professional Psychology: Research and Practice,* 39(2), 218-228. https://doi.org/10.1037/0735-7028.39.2.218

Molm, L., Schaefer D. R. and Colett, J. (2009). Fragile and resilient trust: risk and uncertainty in negotiating and reciprocating exchange. *Sociological Theory* 27:1-32. https://doi.org/10.1111/j.1467-9558.2009.00336.x

Moodley, R., Uwe, Gielen, & WU, R. (2013). *Handbook of Counseling and Psychotherapy in an International Context.* Taylor & Francis Group, LLC. https://doi.org/10.4324/9780203864906

Morgan, V. R. (2010). Burdens of disclosure: A pastoral theology of confidentiality (Doctoral dissertation, University of Denver). https://doi.org/10.5840/process201140129

Morrison, S. S., Steele, J. M., and Henry L. (2015). Recommendations for Counselors Working With Jamaican Immigrant Families and Children. Article 968, Vistas 2015.

Murry, V. M. Heflinger, C. A., Suiter, S. V. & Brody, G. H. (2011). Examining perception about mental health care and help-seeking among rural African American families of adolescents. *Journal of Youth and Adolescence*, 40(9), 1118-1131. https://doi.org/10.1007/s10964-010-9627-1

Nassaji, H. (2020). Good qualitative research. *Language Teaching Research, 24*(4), 427-

431. https://doi.org/10.1177/1362168820941288

Neely-Fairbanks, S. Y., Rojas-Guyler, L., Nabors, L., & Banjo, O. (2018). Mental illness knowledge, stigma, help-seeking behaviors, spirituality and the African American church. American Journal of Health Studies, 33(4). https://doi.org/10.47779/ajhs.2018.69

Ness, L. (2020). What is transferability in qualitative research. My Dissertation Coach.

Newport, F. (2010). This Christmas, 78% of Americans identify as Christian. Retrieved from http://www.gallup.com/poll/124793/This-Christmas-78- Americans-identify-Christian.aspx

Nguyen, A. W., Taylor, R. J., Chatters, L. M., Taylor, H. O., & Woodward, A. T. (2020) Professional service use among older African Americans, Black Caribbeans, and non-Hispanic Whites for serious health and emotional problems. *Social Work in Health Care*, *59*(3), 199-217. https://doi.org/10.1080/00981389.2020.1737305

Nichols, L. M. (2023). Improving the Biblical and Spiritual Skills and Knowledge of Christian Mental Health Counselors at Grace House Counseling Center in Fleming Island, FL.

Ningi, A. I. (2022). Data Presentation in Qualitative Research: The Outcomes of the Pattern of Ideas with the Raw Data. International Journal of Qualitative Research, 1(3), 196-200. https://doi.org/10.47540/ijqr.v1i3.448

O'Connor, M., & Casey, L. (2015). The mental Health literacy Scale (MHLS): A new scale-based measure of mental health literacy. *Psychiatry Research*, 229, 511-516. https://doi.org/10.1016/j.psychres.2015.05.064

O'Day, R. (2023). The Anatomy of a Profession: the Clergy of the Church of England. In *The Professions in Early Modern England* (pp. 25-63). Routledge. https://doi.org/10.4324/9781003436478-2

Oexle, N., Rüsch, N., Viering, S., Wyss, C., Seifritz, E., Xu, Z., & Kawohl, W. (2017). Self-stigma and suicidality: a longitudinal study. European archives of psychiatry and clinical neuroscience, 267(4), 359-361. https://doi.org/10.1007/s00406-016-0698-1

Office of Archives, Statistics and Research (2017). Atlantic Caribbean Union Mission of Seventh-day Adventists. http://www.adventistyearbook.org/entity?EntityID=32461

Olawuni, M. O. (2020). *Counseling Skills Training: A Catalyst for Efficacy in the Formation of Nigerian Catholic Priests*. Saint Mary's College of California.

Oliver, Willie & Oliver, Elaine (2021). Engage to be Engages? Adventists World. https://www.adventistworld.org/engaged-to-be-engaged/ONS Office for national statistics suicides in GB, 2016 registrations, 2016. Available: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarri

Onwuegbuzie, A. J., & Leech, N. L. (2007). Validity and Qualitative Research: An Oxymoron? Quality and Quantity, 41, 233–249. https://doi.org/10.1007/s11135-006-9000-3

Paley, J. (2017). *Phenomenology as qualitative research: A critical analysis of meaning attribution*. Routledge. https://doi.org/10.4324/9781315623979

Parent, Miriam Stark (2006). Boundaries and Roles in Ministry Counseling. *American*

Journal of Pastoral Counseling, 8(1),1-25. https://doi.org/10.1300/j062v08n02_01

Parker, P. D., & Martin, A. J. (2011). Clergy motivation and occupational well-being: Exploring a quadripolar model and its role in predicting burnout and engagement. *Journal of Religion and Health*, 50(3), 656-674. https://doi.org/10.1007/s10943-009-9303-5

Parle, S. (2012). How does stigma affect people with mental illness? *Nursing Times* 10.07.12 / Vol 108 No 28 / www.nursingtimes.net. https://doi.org/10.1037/h0094497

Parcesepe, A. M., Cabassa, L. J. (2012). Public Stigma of Mental Illness in the United States: A Systematic Literature Review, Administration and Policy in Mental Health and Mental Health Services Research 40(5). https://doi.org/10.1007/s10488-012-0430-z

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

Patton, M. Q. (2015). Qualitative research & evaluation methods: Integrating theory and practice. Sage publications.

Payne, J. S. (2008). "Saints Saint don't cry"; Exploring Messages surrounding depression and mental health treatment as expressed by African-American Pentecostal preachers. *Journal of African American Studies*, 12(3), 215-228. https://doi.org/10.1007/s12111-008-9044-7

Payne, J. S. (2009). Variations in pastors' perceptions of the etiology of depression by race and religious affiliation. *Community Mental Health Journal*, 45(5), 355-365. https://doi.org/10.1007/s10597-009-9210-y

Payne, J. S. (2014). The influence of Secular and Theological education on Pastors' depression intervention decisions, *Journal of Religion and Health*, 53(5), 1398-1413. https://doi.org/10.1007/s10943-013-9756-4

Payne, J. S., & Hays, K. (2016) A spectrum of belief: a qualitative exploration of candid discussions of clergy on mental health and healing, Mental Health. *Religion & Culture,* 19:6, 600-612. https://doi.org/10.1080/13674676.2016.1221916

Perry, D. A. & Pierre E. O. (2021). Even the Best of Us: Clergy Sexual Failure--The Church's Hidden Sin. https://books.google.com/books?hl=en&lr=&id=uP8hEAAAQBAJ&oi=fnd&pg=PR9&dq=related:P2tzLXzt3IgJ:scholar.google.com/&ots=m43iS2sVIJ&sig=zItBbhF_Ihll7KBVWlkdJgN07Uo#v=onepage&q=citation%20&f=false

Peteet, J. R. (2019). Approaching Religiously Reinforced Mental Health Stigma: A Conceptual Framework, Psychiatric Services 2019; 70:846–848; https://doi.org/10.1176/appi.ps.201900005

Philo, K. (2018). The Caribbean Immigrants Who Transformed Britain. *The New Republic Magazine.* June 22, 2018. https://newrepublic.com/article/149293/caribbean-immigrants-transformed-britain-windrush-generation

Poling, J. N. (2005). God, sex and power. Theology & Sexuality, 11(2), 55-70.

https://doi.org/10.1177/1355835805051878

Poole, T. G. (2017). Black families and the Black church: A sociohistorical perspective. In Black families (pp. 33-48). Routledge. https://doi.org/10.4324/9781351316323-4

Rajasinghe, D. (2020). Interpretative phenomenological analysis (IPA) as a coaching research methodology, Coaching: *An International Journal of Theory, Research and Practice*, 13:2, 176-190. https://doi.org/10.1080/17521882.2019.1694554

Rankin, W. W. (2019). Confidentiality and clergy: Churches, ethics, and the law. Wipf and Stock Publishers.

Rayburn, C. A. (2014). Psychotherapy with Seventh-Day Adventists. In P. S. Richards & A. E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (pp. 207–230). American Psychological Association. https://doi.org/10.1037/14371-009

Reed, E. S. (1997). From soul to mind: The emergence of psychology, from Erasmus, Darwin to William James. New Haven, CT; Yale University Press. https://doi.org/10.12987/9780300147230

Roney, C. (2020). Rural Clergy's Education, Training, Beliefs About Mental Illness, and Referral Practices to Mental Health Professionals (Doctoral dissertation, Regent University).

Rowland, M. L., & Isaac-Savage, E. P. (2014). As i see it: A study of African American pastors' views on health and health education in the black church. *Journal of Religion and Health*, 53(4), 1091-1101. https://doi.org/10.1007/s10943-013-9705-2

Sallay, V. (2019). *USING INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS (IPA) TO ASSESS RECOVERY PROCESSES-QUALITATIVE ANALYSIS OF EXPERIENCE AND IDENTITY*– (Doctoral dissertation, University of Szeged Budapest).

Sanchez, R., Gelabert, R., Baldilla, Y. & Del Valley, C. (2016). Feeding Holy Bodies: A Study on the Social Meaning of a Vegetarian Diet to Seventh-day Adventist Church Pioneers. HTS TeologieseStudies/Theological Studies72: A3080. https://doi.org/10.4102/hts.v72i3.3080

Sanders, R. K. (Ed.). (2013). Christian counseling ethics: A handbook for therapists, pastors & counselors. InterVarsity Press.

Sanders Thompson, V. L., Bazile, A., & Akbar, M. (2004). African Americans perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice*, 35(1), 19-26. https://doi.org/10.1037/0735-7028.35.1.19

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., … Jinks, C. (2018). Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality & quantity*, *52*(4), 1893–1907. https://doi.org/10.1007/s11135-017-0574-8

Segen's Medical Dictionary. (2011). Retrieved December 4 2023 from https://medical-dictionary.thefreedictionary.com/mental+health+professional

Seventh-day Adventist World Church Statistics 2016, 2017, (2018). Silver Spring, USA. https://www.adventist.org/en/information/statistics/article/go/-/seventh-day-adventist-world-church-statistics-2016-2017

Seventh-day Adventist World Church Statistics 2021(2022). *Office of Archives, Statistics, and Research*, General Conference of Seventh-day Adventists Updated February 14, 2022. https://www.adventist.org/statistics/

Schutt, R. K. (2006). Investigating the social world: The process and practice of research (5 ed.). Thousand Oaks, CA: Pine Forge.

Schwandt, T. A., Lincoln, Y. S., & Guba, E. G. (2007). Judging interpretations: But is it rigorous? trustworthiness and authenticity in naturalistic evaluation. New Directions for Evaluation (114), 11-25. https://doi.org/10.1002/ev.223

Shupe, A. (2007). Spoils of the kingdom: Clergy misconduct and religious community. University of Illinois Press. https://doi.org/10.5860/choice.45-1993

Smietana, B. (2014). Mental illness remains taboo topic for many pastors. LifeWay research. Retrieved from http://www.lifewayresearch.com/2014/09/22/mental-illness

Smith, A. E., Riding-Malon, R., Aspelmeier, J. E., & Leake, V. (2018). A qualitative investigation into bridging the gap between religion and the helping professions to improve rural mental health. *Journal of Rural Mental Health, 42*(1), 32. https://doi.org/10.1037/rmh0000093

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Sage.

Smith, J. A., & Fieldsend, M. (2021). *Interpretative phenomenological analysis.* American Psychological Association. https://doi.org/10.1037/0000252-008

Solarino, A. M., & Aguinis, H. (2021). Challenges and best-practice recommendations

for designing and conducting interviews with elite informants. *Journal of Management Studies*, *58*(3), 649-672. https://doi.org/10.1111/joms.12620

Stahl, N. A., & King, J. R. (2020). Expanding approaches for research: Understanding and using trustworthiness in qualitative research. Journal of Developmental Education, 44(1), 26-28.

Stewart-Sicking, J.A., Ciarrocchi, J.W., Hollensbe, E.C., & Sheep, M.L. (2011). Workplace characteristics, career/vocation satisfaction, and existential well-being in Episcopal clergy. Mental Health, Religion, & Culture. 14(7), 715-730.

Stull, L. G., Harness, J., Miller, M., & Taylor, A. (2020). Attitudes About Mental Illness Among Seminary Students: a Qualitative Analysis. Journal of religion and health, 59, 2595-2610. https://doi.org/10.1007/s10943-020-01045-0

Sullivan, S.; Pyne, J. M.; Cheney, A. M.; Hunt, J.; Hayes, T. F.; Sullivan, G. (2013). South Central Mental Illness Research, Education and Clinical Center, Central Arkansas.

Sullivan, S.; Pyne, J. M.; Cheney, A. M.; Hunt, J.; Hayes, T. F.; Sullivan, G. (2013).The Pew Versus the Couch: Relationship between mental health and faith communities and lessons learned from a VA/clergy partnership project. *Journal of Religion and Health*, 53,1267-1282. https://doi.org/10.1007/s10943-013-9731-0

Sutton, B. (2023). *Lived Experiences of Non-Licensed African American Pastors Providing Counseling for Race-Related Mental Health Issues to Their Parishioners* (Doctoral dissertation, Walden University).

Taubes, T. (1998) (as cited by Kooing, 2012). "Healthy Avenues of the Mind: Psychological theory building and the influence of Religion during the era of Moral Treatment," American Journal of Psychiatry, vol. 155,no.8, pp. 1001-1008, 1998. https://doi.org/10.1176/ajp.155.8.1001

Taylor, R. Woodward, A., Chatters, L., Mattis, J. S., & Jackson, J. (2011). Seeking help from clergy among Caribbean in the United States. Race and Social Problems 1-11. Doi: 10.1007/s12552011-9056-0. https://doi.org/10.1007/s12552-011-9056-0

The Gallup Organization, (2020; 2021). Washington, D.C.: Gallup Organization. https://news.gallup.com/poll/341963/church-membership-falls-below-majority-first-time.aspx

Thomas, M. L. (2012). The inter-professional collaborative practice: Clergy persons and mental health professionals, *Pastoral Psychology*, 61, 99-112, https://doi.org/10.1007/s11089-011-0408-x

Thompson, W. E. (2008). The church and the sub-culture. WE Thompson - International *Journal of Bahamian Studies*, 2008 - journals.sfu.ca. https://doi.org/10.15362/ijbs.v4i0.93

Tien, L., Davis, A., Arnold, T. H., Benjamin, G. A. (2012). Ethics for Psychologist A Casebook Approach. SAGE Production Ltd.

Tobin, G. A. & Begley, C. M. (2004). Methodological rigour within a qualitative framework, Methodological issues in nursing research. *Journal of Advanced Nursing* 48(4), 388–396. https://doi.org/10.1111/j.1365-2648.2004.03207.x

Tuffour, I. (2017). A critical overview of interpretative phenomenological analysis: A

contemporary qualitative research approach. *Journal of Healthcare Communications*, *2*(4), 52. https://doi.org/10.4172/2472-1654.100093

VanderWaal, C. J., Hernandez, E. I., & Sandman, A. R. (2012). The gatekeepers: Involvement of Christian clergy in referrals and collaboration with Christian social workers and other helping professionals. *Social Work and Christianity*, 39(1), 27–51. https://doi.org/10.17744/mehc.39.3.04

Vermaas, J. D., Green, J., Haley, M., & Haddock, L. (2017). Predicting the mental health literacy of clergy: An informational resource for counselors. *Journal of Mental Health Counseling*, *39*(3), 225–241. https://doi.org/10.17744/mehc.39.3.04

Vespie, Stanley Paul (2010). Attitudes of Southern Baptist Pastors Toward Professional Counseling. Walden University, ProQuest Dissertations Publishing, 2010. 3432439.

Villas Boas, A. (2020). Spirituality and health in pandemic times: lessons from the ancient wisdom. Religions, 11(11), 583. https://doi.org/10.3390/rel11110583

Vitus, K. (2008). The agonistic approach: Reframing resistance in qualitative research. Qualitative Inquiry. 2008;14(3):466–488. http://dx.doi.org/10.1177/1077800407309331

Walker, K. R., Scheidegger, T. H., End, L., and Amundsen, M. (2012). The Misunderstood Pastoral Counselor: Knowledge and Religiosity as Factors Affecting a Client's Choice Paper based on a program presented at the 2012 American Counseling Association Annual Conference and Exposition, San Francisco, CA, March 23-25.

Wang, P. S.; Berlund, P. A., & Kessler, R. C. (2003). Patterns and correlates of contacting clergy for mental disorder In the United States. Health Services Research, 38(2), 647-673. https://doi.org/10.1111/1475-6773.00138

WANGARU, D. N. A. A. (2019). Factors influencing adherence to counselling ethics among church based counselors in Uasin Gishu County, Kenya (Doctoral dissertation, Moi University).

Weaver, A. J., Flannelly, L. T., & Oppenheimer, J. E. (2003). Collaboration between clergy and mental health professionals: A review of professional health care journals from 1980 through 1999. Counseling and Values, 47(3), 162-171. https://doi.org/10.1002/j.2161-007X.2003.tb00263.x

Weger, H. Jr., Castle, G. R. & Emmett, M. C. (2010) Active Listening in Peer Interviews: The Influence of Message Paraphrasing on Perceptions of Listening Skill, The Intl. Journal of Listening, 24:1, 34-49, https://doi.org/10.1080/10904010903466311

Whaley, A. L. (2001). Cultural mistrust and mental health services for African Americans: A review and meta-analysis. The Counseling Psychologist, 29(4), 513-531. https://doi.org/10.1177/0011000001294003

Wilder, E. J., Garzon, F., & Johnson, E. L. (2020). A Christian multi-modal approach to therapy utilizing inner healing prayer: The life model. Journal of Psychology and Christianity, 39(1), 49-64.

Wong, W. (2009). Retracing the footsteps of Wilhelm Wundt: Explorations in the disciplinary frontiers of psychology and in Völkerpsychologie. *History of*

Psychology, 12(4), 229–265. https://doi.org/10.1037/a0017711

Wood, E., Watson, R., & Hayter, M. (2011). To what extent are the Christian clergy acting as frontline mental health workers? A study from the North of England. *Mental Health, Religion & Culture*, *14*(8), 769-783. https://doi.org/10.1080/13674676.2010.522565

Woodward, A. T., Taylor, R. J., Bullard, K. M., Neighbors, H. W., chatters, L. M. & Jackson, J. S. (2008). Use of Professional and informal support by African Americans and Caribbean blacks with mental disorders. *Psychiatric Services*, 59(11), 1292-1298. https://doi.org/10.1176/ps.2008.59.11.1292

Woodward, A. T., Chatters, L. M., Taylor, R. J., Neighbors, H. W., & Jackson, J. S. (2010). Differences in professional and informal help seeking among older African Americans, Black Caribbeans and Non-Hispanic Whites. *Journal of the Society for Social Work and Research*, 1(3), 124–139. https://doi.org/10.5243/jsswr.2010.10

World Health Organization (WHO) (2004). Promoting mental health: concepts, emerging evidence, practice (Summary Report) Geneva: World Health Organization; 2004. [Google Scholar]. https://doi.org/10.1037/e538802013-009

Wright, J. (2021). African American Pastors' Perspective on Mental Health Care After Clinical Pastoral Education (Doctoral dissertation, Capella University).

Yin, R. K. (2013). Validity and generalization in future case study evaluations. *Evaluation*, *19*(3), 321-332. https://doi.org/10.1177/1356389013497081

Young, J. (2010). More than a prayer: Pastors' perception and practice of mental health

services.

Young, J. L., Griffiths, E. E. H., & Williams, D. R. (2003). The integral role of pastoral counseling by African-American clergy in community mental health. *Psychiatric Services, 54*(5), 688-692. https://doi.org/10.1176/appi.ps.54.5.688

Zarb-Cousin, A. W. (2020). *Serving Those Who Spiritually Serve Us: Understanding the Lived Experiences of Clergy Members Who Have Accessed and/or Received Mental Health Services.* Our Lady of the Lake University.

Zong, J., Batalova, J. (2019). Caribbean Immigrants in the United States, Immigration Policy Institute. https://www.migrationpolicy.org/article/caribbean-immigrants-united-states

Appendix A: Interview Guide

Demographic Questions

1. What is your age?
2. What is your education level?
3. How do you describe your ethnicity?
4. How long have you worked in your capacity as pastor?
5. How many different churches have you pastored so far?
6. How many countries have you served?

Research Question #1

RQ primary. What are the Seventh-day Adventist Caribbean Pastors' experiences in addressing their parishioners' mental health consultations?

Interview Questions for RQ1:

1. Tell me about your daily activities at the church.
2. Please describe the most common type of parishioners' consultations you receive.
3. How would you describe parishioners' consultation that you would classify as mental health consultations?
    a. Probe: Please give me examples of mental health consultations you receive.
4. How do you address your parishioners' mental health consultations?
5. What is your experience with a parishioner who had mental health challenges?
    a. How do you identify mental health challenges?

   b. How do you proceed when you have a consultation from a parishioner who have mental health challenges?

6. How frequently and freely do parishioners seek pastoral intervention for challenges that you classify as mental health challenges?
7. How did you get knowledge to deal with the parishioners' mental health consultations?
   a. How would you describe your expertise to detect and provide appropriate first response to parishioners who have mental health challenges?
   b. How effective has your pastoral support been in instances of mental health consultations?
8. What is your experience consulting with someone else about your parishioner's mental health consultation?
9. What is the established mental health referral system/protocol of your church?

RQ.2. How do Seventh-day Adventist Caribbean Pastors describe the training received to serve their parishioners' mental health consultations?

INTERVIEW QUESTIONS FOR RQ2:

1. Please describe the training you received to serve your parishioners' mental health consultations.
   a. What was your experience in that training?
   b. What aspects of this training you found most helpful in addressing parishioners' mental health consultations?

2. If formal training was received, how adequately do you think the training prepared you to serve these consultations?
    a. How do you think your degree of preparedness compares to mental health practitioners' preparedness?
3. Please tell me if you ever consult with others within or outside the church about your parishioners' mental health consultations.
4. What recommendation would you make regarding training to address parishioners' mental health consultations?