ABSTRACT

DEALING WITH DEPRESSION:

FACTORS THAT CONTRIBUTE TO THE PRESENCE OF MAJOR DEPRESSION DISORDER AND ITS IMPACT IN HISPANIC PASTORS OF CHURCH OF GOD IN SOUTHEAST REGION

by

Nelson Parra

Major depressive disorder is a fact in the world. Major depressive disorder can cause severe impairment in social and physical functioning and is frequently a major precipitating factor in suicide. Denominations and churches are now experiencing this reality. Little emphasis is placed on the emotional health of ministers in general, and even less on leading and non-leading pastors among the Hispanic population living in Florida (U.S.A). The underlying assumption is that if the Hispanic minister's spiritual life is in the right order, then other aspects of their lives will fall naturally into place. This way of understanding the problem is subconsciously minimizing the impact that symptoms of depression can cause in the lives of those ministers

The purpose of this study was to describe the presence of major depressive disorder in Hispanic Pastors of the Church of God, southeast region. The research utilized two instruments for data gathering: (1) A questionnaire with demographic information where participants indicated their level of knowledge about major depressive disorder and whether they are experiencing symptoms of depression, how often these symptoms appeared and how those symptoms are affecting their emotional status; and (2) The Beck

Depression Inventory II (BDI), a self-rating scale based on the most common symptoms among depressed individuals.

The analysis then described the phenomenon of depression among Hispanic ministers, causes, stressors, emotional exhaustion, reticence to reveal depression symptoms and the preparation for future actions in terms of treatment.

The study also presented the reported most common depressive symptoms and how physical and mental issues combined with the lifestyle, pastoral duties, and other factors contribute to the presence of depression. Additionally, the study exposed the numerous causes of depression, but specific for Hispanic ministers according to literature. It also verified the conservative tendencies Hispanic pastors have regarding depressive disorder, evidencing the need to work in an especial treatment involving clinical and spiritual nourishment to help this population reduce the predictable and devastating effects of the phenomena of depression.

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by

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TABLE OF CONTENTS

LIST OF TABLES

ACKNOWLEDGEMENTS

This study is dedicated to pastors who are struggling with symptoms of depression. It is my hope that someday our society will recognize the symptoms of depression in pastors without distinction rather than being distracted by religious stigma. Through immediate treatment of the real present issues, pastors will be able to better their lives and ministry and be true to themselves.

I would like to express my deepest appreciation to Dr. David Ramirez. I cannot express the enormous amount of gratitude I have for you being my advisor from my years as a student of theology. The skills and experience I have learned through your guidance are invaluable and has left a significant mark on my life.

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CHAPTER 1

NATURE OF THE PROJECT

Overview of the Chapter

Being a church pastor is perhaps one of the most stressful professions. Its links to depression have been well known in numerous studies and articles. However, the amount of research that has been done linking major depressive disorder in the Hispanic ministers is significantly meager. The Southeast region of Church of God Hispanic ministry is the focus of this study. Multiple factors, stressors, and causes are the platforms to analyze why depression is a growing problem and how we can implement an appropriate follow-up plan in the future to prevent and treat depression symptoms experienced by this population in the Church of God Hispanic Ministry.

Personal Introduction

Ever since I started attending church, I remember having the opportunity to meet pastors who were constantly complaining about their life, work, and families and how ungratifying it was to work as ministers. Many of them even vented to me despite my young age. As a clinical mental health counselor, I can understand now that was probably happening. They were experiencing depression symptoms, seeking for help, and looking for someone who was able to listen. However, it was not an easy task for them to find someone who was available, professional, and confidently able to provide some help. Even worse, they did not know how to deal with those feelings. Unfortunately, even today, some of them lack the opportunity to speak to someone prepared to help them in the process of exploring their thoughts and emotions.

Most Christian leaders are aware of the challenge's depression presents within the context of ministry. In fact, Christian church culture has created the perfect environment for ministers to feel as lost, intimidated, and fearful as most others. This is not only because some of them are unable to seek help, but because Christian culture and the modern society give them only one option: "suffer in silence". The result of the phenomenon is evidenced when pastors and leaders abandoned the ministry or even worse when some of them decided the unthinkable.

Being a pastor is a very high-profile job with a high stress level mixed with very difficult expectations for success. Those characteristics can send anyone to experience depression symptoms. Some of those pastors that I have known were people pleasers, and they got easily frustrated, feeling that they were unable to continue to please everyone. Most of them failed to live up to all those demands imposed by themselves and others, and they turn their frustration back on themselves. The results are self-doubt and feelings of failure, frustration, hopelessness, and loneliness.

Most of the counselors I know agree that nearly 50% of depressed people don't seek help or treatment. Even fewer pastors in the context of the variety of denominational and non-denominational churches get treatment for depression (Huffington, 2015). When it comes to how Hispanic pastors in Latin America handle depressive symptoms, they do not seek treatment because there are several distorted perspectives about mental illness, or they simply do not have access to a professional clinical treatment. Pastors and Hispanic ministers living in Florida do not seek help because of several reasons such as career fear, spiritual taboo, or social stigma. Hispanic leaders all share the same reasons for not having treatment. They do not talk about it because they think it violates the

understanding of their faith. In the environment where they develop their ministry, they are not permitted to have those kinds of thoughts and feelings associated with depression. Society still places a stigma on those having mental illness. Unfortunately, the wrong perspective some Christians have about this kind of phenomenon seems to make it worse to dismiss depression as a lack of faith or just as a sign of a weak minister. Other factors of depression in Hispanic ministers include multicultural background, enculturation processes, different habits and customs, immigration processes, people having or not having legal documents, among other factors. All of these play a significant part in the lives of those ministers suffering depression.

Christians lives in a culture of avoidance, where we can talk about depression of others but not among themselves. Also, they avoid speaking about depression before or after symptoms occurred but not when the phenomenon is occurring. For this reason and based on the lack of an appropriate clinical strategy and intentional program directed for this specific population experiencing depression, the purpose of this study is to describe the presence of major depressive disorder among Hispanic pastors of the Church of God in Florida and to investigate what strategies these pastors typically employ to deal with major depressive disorder. The study includes the analysis of cognitive therapeutic perspectives and other alternative approaches about major depressive disorder. The description of alternative approaches, perspectives and therapeutic instruments, medications, and others are because depression is totally treatable.

Statement of the Problem

The backbone of this study is to obtain a description of major depressive disorder's indicators among Hispanic leading and non-leading pastors of the Church of

God in Florida' state. The church as it relates to pastors and ministers in general, has ignored depression as a mental health issue for many decades. Major depressive disorder is no longer a problem reserved for "other people" in the Hispanic community. The illness is a common, chronic, and frequently a recurrent disorder affecting all levels of the church and those involved in the ministry as pastors regardless of their cultural background. Its significant consequences can come from mild to barely observable sub-clinical effects to disabling symptoms. Depression, as one of the most devastating psychiatric disorder forms, is not only the leading cause of disability in the world for people between 15 and 44 years old (Reddy, MS, 2010). It also contributes to decreased productivity, increased absenteeism, addictions, reckless behavior, poor performance, social relationship problems, health issues, and even suicidal tendencies (Leahy 2012). Of all diseases, depression is only exceeded by lower respiratory infections, perinatal conditions, and ischemic heart disease, and VIH/AIDS among others in terms of disability during a person's lifetime (World Health Organization 2004).

Depression is somehow an epidemic among ministers. Hispanic pastors will at one point of their lives experience depression whether mild or severe (Randal, 1998). However, due to lack of information, distorted theological perspective, or many other reasons, many pastors do not recognize mental health institutions as the most appropriate places to treat depression. The results are the lack of treatment, poor institutional attention, and the absence of an appropriate risk reduction programs to deal with depression. This phenomenon has resulted in negative consequences for the life of those working for the Kingdom of God and their families, bringing devastating results not only for them but also for the churches those pastors lead (Bryant, 2013).

Purpose of the Project

The purpose of this study was to identify factors that contribute to the presence of major depressive disorder in Hispanic pastors of the Church of God in Southeast Region (Florida), and its impact on their ministries to make recommendations to address this problem**.**

Research Questions

To fulfill the purpose of this study, the following questions were asked:

Research Question #1

What are the most common symptoms of major depressive disorder among leading and non-leading pastors in the Church of God Hispanic Ministry Southeast Region?

Research Question #2

What are the most common causes that contribute to the growing problem of Major Depressive Disorder among leading and non-leading pastors of the Church of God Hispanic Ministry Southeast Region?

Research Question #3

What are the most typical and popular non-formal approaches this population use to deal with depression symptoms?

Research Question #4

How does the severity of Major Depressive Disorder affect the life and ministry of pastors of the Church of God Hispanic Ministry Southeast Region?

Rationale for the Project

Major depressive disorder is not just a problem in the life of those working in ministry but also one of the highest growing epidemic problems among the Hispanic population. In a recent article, the New York Times said: “The findings have surfaced with ominous regularity over the last few years, and with little notice: Members of the clergy now suffer from obesity, hypertension, and depression at rates higher than most Americans. In the last decade, the use of antidepressants has risen, while the life expectancy of those working in ministry has fallen. Many would change jobs if they could” (Vitello, 2010).

This study of major depressive disorder’s symptoms was grounded in the Scriptural understanding of 1 Corinthians 4:2, that pastoral leaders are individuals that serve as models and influencers for their own families and churches (NIV). For many years, pastors struggle with depression and other mental disorders without any clinical or professional attention (Barna, 2020). Stories about pastors who committed suicide are common. Others have left or are leaving their ministries. Some of them are feeling lost, abandoned, and overwhelmed. Manu statistics exist about pastors experiencing depression, burnout, even psychosomatic health problems, and other mental issues. However, none of the pastors are receiving the needed help. According to the Schaeffer Institute, *seventy* percent of pastors constantly fight depression, and seventy-one percent are burned out. Meanwhile, 80 percent believe pastoral ministry has negatively affected their families; and seventy percent say they do not have a close friend. (R.J. Krejcir, 2007). Definitively, more research is needed to understand and overcome this phenomenon to understand it and overcome it.

When depression or any other mental health crisis hits, it should not catch a minister off guard. The reality is that many ministers seem to live dulled lives, devoid of deeper purpose and meaning. Hispanic Pastors are not far from this reality, living passionless and visionless. The intensely competitive culture that rewards success and achievement makes our identity become the simple reproduction of these external indicators of achievement. The main idea of being a minister of God now is terribly misdirected, straining Hispanic Pastors' emotional and spiritual balance well beyond its healthy balance. Many of those ministers are now disconnected and, in some cases, isolated. When this occurs, Hispanic pastors tend to spiritualize everything they do, even tending to relativize the importance of their work as a way of psychologically compensating for the low wages. Others just start seeking for material acquisitions to compensate for their frustration and lack of meaning of what they are doing as ministers. (Robertson, 2011)

Depression causes lot of negative effects in the life of Hispanic Church leaders, churches, and ministries in America. Twelve percent of men and twenty six percent of women will experience major depression in their lifetime, per the American Medical Association (Kessler R.C, 2003). "The probability is that one out of every four pastors is depressed", said Matthew Stanford, a professor of psychology (Ridgaway, 2013). Problems like anxiety and depression are present in the pulpit. Factors such as economic crisis, poor church budgets, the need of having an extra job to support families, cultural change due to immigration processes, and other social phenomena have caused many pastors to fall into deep levels of depression that urgently need attention. Those symptoms of depression are going to be reflected in the pastor's work, reporting

frustration over their congregations, and subsequently affecting the normal development of the church as an agent of cultural change (Ridgaway, 2013).

The reality of many of our Hispanic ministers is isolation. Having an attitude of loneliness in addition to not having the appropriate help contributes to depression. Being a Minister is a high-stress job, with a very low expectation for success. In most cases, those ministers do not know why their souls struggle or how to deal with symptoms of depression, frustration, and burn out. making their daily life more difficult. Major depressive disorder among ministers is as prevalent in Hispanic leading and non-leading pastors as in the general population and can be noticeable when pastors are transmitting their teachings from the pulpit. Self-doubt, feeling of failure, hopelessness, and dealing with other people's problems increasingly reproduce feelings of frustration and negative symptoms.

A good number of Hispanic pastors living in the Florida area recently moved from their countries of origin and are currently waiting for their legal residence status to be resolved. In this regard, studies like acculturation strategies (Berry 2001) and general models of acculturation processes (Ward 1996) provide a very interesting study of psychological effects of acculturation and resettlement in immigrant population. Those processes require another psycho-sociological adaptation adjustment to the host culture. Those immigrant pastors are familiar with the significant nostalgia of past experiences leading communities in their original contexts, reciprocating the psalmist's feelings of longing regarding his ministry. Psalm 42:4 reflect it as "These things I remember, as I pour out my soul: how I would go with the throng and lead them in procession to the

house of God with glad shouts and songs of praise, a multitude keeping festival" (Franquiz, 2010).

Most ministers are experiencing the same depression symptoms regardless of what country they come from. Franqúiz made a brief description of those acculturation processes that contribute to emotional distress in Latino immigrants, such as changes of environment, changes in diets and food and customs, having to re-learn another culture, and another way of living (Cantu and Franquiz).

Depression's symptoms affect not only the lives and ministries of the pastors living with depression but also their entire families and communities. It hurts the lives of men and women who were once called to work in the Kingdom of God. Depression is real, and it is urgent to establish a good understanding of it and to implement a future follow-up plan directed specifically for leading and non-leading Hispanic pastors experiencing major depressive disorder

Another reason to address major depressive disorder among Hispanic leading and non-leading pastors is that for many years, many believed that the mere fact of being Christian resolved emotional and behavioral problems. Those problems have not been resolved yet and are still a growing concern among us. The Scripture and theology are the Christian's foundation, and within that cognitive frame exists an integrated psychology that can help people deal with behavioral and mental health issues. The mind, emotions, behaviors, how individuals treat people, marriage, depression, and anxiety are all there, and Christians need to take care of them as an integrative part of their being. Once people have their Biblical and Theological foundation, they must then build upon it. The acceptance of auxiliary sciences that complement the Scripture and theology is important

and is needed. Now, if it does not complement the Scripture or theology, then Christians should reject it, knowing that their foundation is God's Word (Hart, 2015).

What does the Scripture say about helping those suffering from depression? The foundation of this study is that we were made in the image of God. But what it means to be created in the image of God is an understanding of three theoretical aspects: how God made us, what we wrongly changed, and how to get back to His design. The process is not as simple as it appears, especially when a pastor wrongly says, "I want to do it in my way." It is important to have a clear integration of scriptural foundations and psychological approaches. This requires us to bring to the table our intention to work with an open discussion about how to understand this phenomenon and how to treat depression from a clinical perspective within the frame of what God's design is.

Definition of Key Terms

In this study, several terms require definition.

Beck Depression Inventory (BDI II) is a 21 item self-report rating inventory that measures characteristic attitudes and the most common symptoms of depression (Beck & Rush p.389).

Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. Also, it is called clinical depression or major depressive disorder and affects how you feel, think and behave, in some cases leading an individual to a variety of physical and emotional problems (WHO, 2012) (DSM-5, 2013).

Delimitations

The population for this study was an available sample of Hispanic lead and non-leading pastors, principally within the Southeast Region of the Church of God

denomination in Florida. Each of them was invited to voluntarily participate. The samples were received as authorized by the Southeast Hispanic Church's oversee, the board of elders or senior pastor. The study is therefore limited, and the findings are only generalized to those Hispanic lead and non-leading pastors of Florida.

Variables that affect the outcome of the study include basic personal and demographic factors. The willingness and capacity of each of the participants is the variable, taking into consideration the honesty in each response and knowing that there are emotions which tend to produce barriers of authenticity. Also, the demographic factor includes the tenure of the Hispanic pastor, social profile and the size of the church, cultural background, the historical age of the pastor's ministry, and the geographical region of the participants. Participants are primarily immigrants from South and Central America but included those that were born in Latino Families in North American territory and Puerto Rico. Some of the participants were born as second generation in the United States territory. It means they were born in immigrant Latino families. The Church of God Hispanic Ministry in the southeast region are experiencing an important growth in terms of integrating multi-Latino pastors from all over South and Central America. The findings have direct implications for the Church of God Hispanic Ministry in Florida as it seeks a better understanding of the phenomenon and how to obtain and formulate effective methods to assist Pastors experiencing depression symptoms.

Review of Relevant Literature

The foundation of this study was laid by the fact that depression is probably the most prevalent reported disorder. Therefore, it is one of the most diagnosed and researched topics by psychologists and mental health practitioners. To have a better

understanding of how Hispanic pastors might experience depression, The *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*, the standard classification of mental disorders used in the context of United States, published by the American Psychiatric Association, was used to ensure uniformity of diagnosis. However, it is possible to use some modified criteria, if needed, to have a more accurate diagnosis, based on cultural differences or similitudes, age and other aspects of the multicultural characteristics of participants.

The literature of this study can be divided into two groups. The first one includes authors that describe the nature of depression based on the diagnostic criteria from the DSM-5. The second group in the literature provides the introduction to treatment therapeutic approaches that apply to the problem, such as cognitive behavioral therapy, among others. This study is not focused on developing a clinical treatment plan now but to prepare the way to suggest an appropriate future approach to be used on the determined population.

Aaron T Beck provided for the study the Beck Depression Inventory to measure the characteristics, attitudes, and symptoms of depression. Beck and Brad A. Alford also provided information in their book *Depression: Causes and Treatment.* Additionally, Beck, John Rush, Brian Shaw, and Gary Emery have a valuable book used in this study: *Cognitive Therapy of Depression* (Aaron T. Beck M. J., 1979). Authors and works referenced include Amber Rain in his book *Depression Signs, Symptoms and Treatment;* Welton Gaddy with his book, *A Soul under Siege: Surviving Clergy Depression;* and Archibald D. Hart with *Coping with Depression in the Ministry and Other Helping Professions.*

The focus of our literature was clinical mental health literature, psychology and psychiatry books including those referring to depression as a mental health disorder. The literature is not limited to peer reviewed articles, academic journals, magazines, or other publications.

Since this study is focused on a specific population of Hispanic Christians lead and non-leading pastors in a specific context, additional Biblical and theological literature were an excellent and convenient part of this research. They are discussed in chapter 2.

Research Methodology

The discussion on methodology starts with a description of the subject selection process for the study, the participants involved in testing, the explanation of used procedures, and the discussion of data collection processes.

The researcher previously contacted the bishop administrator of the Church of God Christian Denomination, Hispanic southeast region. The bishop and researcher agreed to open the study to a group of ministers in the southeast region of the church. The bishop administrator made the arrangements for a pastor's group meeting, involving those who may end up participating in the research and providing information regarding the purpose of the study. The researcher delivered a voluntary consent form to all participants via a link before participants proceeded to respond to the questionnaire and the Beck depression inventory test II. A group of at least forty volunteers was identified from the large group of attendees. When each participant received an email with the link, they proceeded to review the informed consent form and confirmed their participation. After they signed the Informed Consent form, they responded to the two instruments. First, they responded to the questionnaire which inquired about demographic information, general

knowledge about depression, and the regularity of the depression symptoms. Second, they took the Beck Depression Inventory test II to complete their participation. All participants were guaranteed confidentiality, and they were not asked to reveal identifying information. Sufficient instruction and information were provided before the clinical questionnaire and the Beck Depression inventory test administration. The proposed assessment strategy in this study was designed to control the possibility of variables associated with multicultural differences.

The purpose of the demographic questionnaire was explained in a brief introduction, followed by questions that did not require participant identification but accepted anonymous responses because many people are sensitive about offering information they consider private. There was no time limit to answer the questionnaire and the test that were administered via a link sent in an email to each participant. The brief clinical questionnaire consisted of twenty-six basic questions used to gather valuable demographic data and information concerning the participant's perception about the existence of depression, including questions related to their depression history. The questions 11-26 related to depression data. Some of the questions are: What knowledge do you have about depression? Have you ever been treated for depression? Have you ever seen a therapist for depression? And have you taken medication for depression? among others. The purpose of this clinical questionnaire was to provide an initial screening tool for the researcher to determine the number of participants experiencing depression. The information helped in the process of categorizing the results.

Participants of this study also answered the Beck Depression Inventory (BDI) test, composed of twenty-one questions with four possible responses designed to measure the

intensity, severity, and depth of experienced depression (Beck A.T., 1961). Additionally, the questions included the evaluation of irritability and hopelessness. Each of the responses were assigned a score ranging from zero to three that indicated the severity of the symptom. The BDI usually takes between five and ten minutes to be complete, as part of a psychological examination, which in terms of time, does not represent major interference during development. The participants were required to have a fifth to sixth grade of reading level to adequately understand the questions (Groth-Marnat, 1990). The result shows the most common symptoms of depression experienced by the participants in the last two to four weeks. The BDI test is frequently a self-administered test, which facilitates its development.

The Beck Depression Inventory test II says depression is composed of three basic aspects: performance impairment, negative attitudes toward the self, and bodily (somatic) disturbances. The Beck Depression Inventory has been extensively tested for validity and reliability based on standards of psychological tests. Internal consistency for the BDI ranges from .73 to .92 with a mean of .86, showing clinical ratings of depressive disorder in at least 90% of all cases (Beck, 1988). For this reason, this study uses the BDI test II, which has become one of the most widely used measures to assess depressive symptoms and their severity in adolescents and adults.

This quantitative method of research also used a cross-sectional case-control design. Participants experiencing symptoms of depression were compared with those non-depressed participants to determine how those groups differ from each other in relation to the perception of quality of life and distorted thinking. The advantage of this

method is that subjects are deliberately exposed, treated or not treated, hence there are seldom ethical difficulties (Mann, 2003).

This study's case-control design means that the relationship among variables was observed but not re-directed or controlled. The results of this study were correlational and not predictive. In consequence, this type of study is useful to produce hypotheses that can be tested using different types of study.

In addition, this study used the applied research method because all participants were adults from different locations of a particular community and not participants in a laboratory setting.

Because this study focuses on a population involved deeply in Christian ministry, several factors make them a unique participant group with specific characteristics. On one hand, the minister cannot always tell if his or her work is having positive or negative results. On the other hand, Hispanic pastors ' work is always a repetitive activity, and they are always dealing with other people's expectations. Hispanic pastors must work with individuals in need of something in several areas which lead the pastor to be an individual with a constant major drain of energy. Several aspects such as loneliness, marital conflicts caused by the ministry, and financial difficulties among others, play an important role in this analysis.

The results, clinical analysis, prognosis, and the future follow up recommendation plans were designed based on a clinical point of view and the scriptural perspective as well. The analysis also provided general information about depression, its causes, and a comprehensive list of treatment options. Additional information of agencies that provide treatment services specifically for depression and help in a crisis were included.

Type of Research

Understanding the role of depression on this population raises significant implications for a description of the problem and the appropriate research to consolidate results. Collecting qualitative and quantitative data and then interpreting that data is the type of research for this study (Creswell, 2003). The questionnaire is a research instrument consisting of a series of structured and focused questions about feelings, beliefs, perceptions, and experiences to gather information from respondents. Although this is not always the case, the questionnaire is often designed for statistical analysis of the responses. To complete the purpose of this study, it will be used as a concise pre-planned set of questions to yield the specific needed information (Salkind, 2011). On the other hand, the questionnaire is the most common method of formal research. The questionnaire used in this research consisted of a common set of questions to which every participant responded. Typically, surveys offer multiple-choice answers or rating scales and sometimes respondents can add comments or information. A key benefit of the questionnaire is that it homogenizes the collection of information so that it is uniform, and interpretation can be reasonably straightforward. In addition, the administration of a questionnaire via a link is frequently intensive than any other method of collecting information (Salkind, 2011).

This quantitative method of research used a cross-sectional case-control design. It means that BDI is used to determine prevalence and infer causation. Prevalence equals the number of cases in a population at a given point in time. Participants experiencing symptoms of depression were compared with those non-depressed participants to determine how those groups differ from each other in relation to the perception of quality

of life and distorted thinking. The advantage of this method is that subjects are intentionally exposed, and consequently there are no space for ethical difficulties (Mann, 2003).

This study also used a case-control design since the relationship among variables were observed but not re-directed or controlled. Case control designs determine the relative importance of a predictor variable in relation to the presence or absence of the symptoms. (Mann, 2003). The results of this study were correlational and not predictive. Consequently, this type of study is useful to produce hypotheses that can be tested using different types of study

A significant amount of literature tells how to gather data, including authors offering insight into major depressive disorder in general and cognitive distortions. Most of this research was focused on how the negative cognition increased levels of depression, which is common in individuals experiencing depression. This descriptive study researched cognitive distortions common in the general population. In summary, the questionnaire and the BDI II test were used as the instruments to gather the needed information to consolidate results as predictors of depression.

Participants

The participants were a multicultural Hispanic sample from different Latino countries living in the Florida area. Pastors from Puerto Rico, Colombia, and Dominican Republic, among other countries, compose the Southeast region Hispanic assembly of the Church of God. Participants are also leading and non-leading pastors of Church of God organization, appropriately authorized by the bishop administrator of the southeast region.

The selected group of participants of this study consisted of at least forty volunteers of leading and non-leading Hispanic Pastors of Church of God in Florida. All the volunteer participants individually completed the clinical questionnaire and the BDI test. The leading and non-leading Hispanic pastors experience a great drain of energy as they minister to others. They are constantly giving of themselves to those in need, taking a toll mentally, physically, and spiritually. When the pastors do not know how to deal with the intangible nature of much of the work, they overextend themselves emotionally and try to validate their ministry. This makes depression inevitable. This population is the main reason for this study.

Instrumentation

Participants were requested to complete a questionnaire that included participant demographic information, questions related to age, ethnicity, education, the household composition including marital status, and professional or employment status. The questionnaire included items designed to establish the participants' capability to evaluate the knowledge level regarding the severity of major depressive symptoms, the participant's perception of their ability and competency to provide accurate information of their own symptoms, and their understanding on the implications of having major depressive symptoms. Additional sections measured the participant's perspectives regarding mental health, mental health professionals, and their perceived competency. Also, they were asked about participant's confidence in mental health professionals and the recognition of their own need for help.

Participants were requested to complete the Beck Depression Inventory test, composed of twenty-one questions, each with a list of four possible responses arranged in

increasing severity designed to measure the intensity, and depth of experienced depression.

Data Collection

The purpose of this study was to describe major depressive disorder symptoms, causes and triggers among Hispanic pastors of the Church of God southeast region and how those symptoms affect their life and ministry. The Beck Depression Inventory was the instrument for data collection, accompanied by a brief clinical questionnaire. These tools were used to assess symptomatology as it correlates with diagnostic criteria for major depressive disorder, as identified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition* (2013). Participants will be taking part in the test individually while they are in a group or not, as needed. Even though it does not require any training to be administered, relevant information and instructions will be provided to obtain the best possible data.

Data Analysis

This study is quantitative, relying on the analysis of data collected by surveying responses and percentages to answer each of the research questions. Responses were organized based on the different topics to determine the frequency of each topic and how it related to the research questions of the study. The length of the responses was limited to only a fraction of data to analyze the phenomena of depression. The study also utilizes descriptive and inferential statistics, briefly describing and summarizing the data from a sample of a specific population.

Generalizability

A lot of research work has been conducted about depression as a mental health disorder. Depression is a big problem, but there is poor information concerning this mental health disorder in this specific population. Major depressive disorder is not reserved only for members of the congregation, but it is a growing problem in all vocational ministry areas. Even though there is literature about depression in general, someone needs to speak about depression in reference to Hispanic pastors of the Church of God southeast region. Most of the Hispanic pastors are experiencing adjustment processes in terms of culture and psycho-sociological needs. Inquiries about the specific causes of depression among Hispanic church leaders living in the United States need to be made. Factors such as social adjustment, feelings of discrimination, church's budget, language difficulties, and family living circumstances among others, should be part of the analysis. The study not only takes into consideration the analysis of the results but also proposes a relevant clinical treatment plan for Hispanic pastors of the Church of God southeast region. A universal plan applicable to other contexts within the Latino community in the United States needs to be prepared. It is also significant that the collected information refers to individuals living in the U.S.A, not those living outside of the country.

Project Overview

Chapter two consists of the literature review supporting this study about major depressive disorder affecting Hispanic lead and non-leading pastors of the Church of God Hispanic Ministry in the Orlando city and Kissimmee area. The literature review includes psychological and Biblical-theological material.

Chapter three presents the methodology of this cross-sectional study, which was designed to understand the issues and causes of depression among Hispanic pastors. The chapter contains the nature and purpose of the project, the sample population, and general information about the participants. It addresses the procedure for collecting and analyzing data, and a description of the instruments that were administrated, followed by statements about the reliability and validity of the study and its ethical consideration.

Chapter four presents the findings of the study. This section contains the restatement of the problem, the procedure for testing, and the outcomes of the study organized by the order of the research questions.

Chapter five reiterates the major points of the study, interprets the findings in the light of literature review, examines ministry implications, defines the limitations of the study, notes unexpected observations, and specifies considerations for future research and recommendations.

CHAPTER 2

LITERATURE REVIEW FOR THE PROJECT

Overview of the Chapter

Where are we in terms of mental health disorder's knowledge, compared to recent decades? Today's psychologists and theologians agree that there is a significant shift in progress in terms of what we know and what we can do with individuals suffering from mental health disorders (Kroll; Stetzer, Pingleton, and Graber). Depression is a fact, and everyone should know that there is help available. However, the discussion today does not question whether this shift is happening but instead concerns how the Christian Church should respond. The response must arise from thorough and appropriate understanding of the fact. The necessity of having a clearer perspective about the problem has given rise to a significant amount of research on how to have a better knowledge of the issue and how to provide an alternative to those suffering major depressive disorder.

This study endeavors to describe the phenomenon of major depressive disorder in pastors of the Church of God Hispanic Ministry in the southeast region. What must be understood before knowing what to do? The phenomenon of major depressive disorder today and the implications that it has for the Hispanic pastors must be understood. Literature from published books, scholarly journal articles, the Bible, online databases and other sources were utilized to provide support to the study. In this chapter, the literature review begins with the Biblical and theological literature that address what the Scripture says about this problem and what it means to provide. Afterwards, the psychological research about depression is discussed. Also, the literature review provides a framework for the study and the fundamentals for an eventual plan of action that could

be developed in the future. At the end of the chapter some important factors are considered along with the outline of the research design for directing the study on the causes and impacts of depression in Hispanic pastors.

Biblical Foundations

In Biblical times, terms like "depression" were not used per se. However, Biblical texts reference persons being depressed or at least experiencing what we call depression symptoms. Some Biblical texts are often used to "encourage others" when dealing with depression.

An Overview of Depression in the Scriptures

In 1Kings 19 Elijah heard Jezebel's death threat towards him, and then he fled for his life and desired to die. Proverbs 12:25 describes succinctly how depression works as an effect of anxiety, but also states that a good word can make the heart glad (NKJV). Psalms 34:17 states that the righteous cry out for God to deliver them from their troubles. The Lord is near to the brokenhearted and saves the crushed in spirit. It means that in Biblical times people were experiencing what today we call depression symptoms. The Scripture has other references about people dealing with depression: Moses (Numbers 11:10-16), David (Psalm 51; 32:1-5), Job, Jonah (Jonah 4:1:11). The Scriptures also reference people willing to commit suicide due to the presence of depression like Saul, defeated by his enemies, and taking positions of a madman, struggling to maintain his position. God rejected Saul to give David his place, and then he fell on his own sword ending his life (1 Samuel 31: 5). Zimri, an evil king, who killed all his relatives and friends, also killed himself (1 Kings 16:18). Ahithophel, the king's counselor, seeing that Absalom had not followed his advice, hung himself (2 Samuel 17:23). The story about

Samson, in Judges 16:29-30 describes him as experiencing depression and committing suicide while in combat with the Philistines. Even the New Testament refers to people dealing with what we call depression symptoms. Judas, who probably did not know how to deal with his thoughts and mental problems, ended up committing suicide after having betrayed Jesus. Mary and Martha were depressed grieving the death of their brother Lazarus (John 11). One of the synagogue leaders named Jairus came to Jesus and fell at his feet pleading about his little daughter who was dying. In the same episode, a woman was there who had been subject to bleeding for twelve years. She had been dealing with doctors, lacked resources and felt hopelessness and for sure was dealing with depression (Mark 5:21:43). These are just some examples.

The Scripture does not provide specific teaching about how to treat the subject from a clinical perspective. In fact, the Scripture is not a clinical manual, but it does know from God's perspective how to deal with depression. These stories in the Bible show that not only was depression real in the old times, but also that God is interested in letting us know that depression was considered as one of the problems human beings will live with. It was documented in the Scripture.

From a biblical perspective, depression is not only a medical or mental problem but also a spiritual problem. Scripture does not deny the medical or emotional aspect of depression. Those aspects need to be treated clinically. But this illness has significant spiritual components deserving a different approach. Proverbs 12:25 is remarkable in its simplicity and provides a good place to begin with a biblical diagnosis. In certain circumstances the heart can begin to bow down, the thoughts can be consumed, and perspective can be lost. A good word is the remedy, especially when it comes from a

supportive person, is timely and measured according to the need of the moment and deliberates grace. People in the Bible faced great depression and anxiety due to worry, doubts, and fear. They suffered because of wars, uncertain future, health, and a whole host of other things. All those things surely led to depression. In Matthew 11:28-30, Jesus refers to all who are weary and burdened. In fact, Moses, David, Job, Peter, Abraham, and others experienced depression not because of what they did or did not do in terms of their mission but because they were human beings. They went through real times of depression caused by spiritual components in their life. Some of the causes are mentioned such as physical tiredness caused by laboring in their own strength and not the Lord's (Colossians 1:28-29). Others had an imbalance between work and sleep or a busy time of life that has taken a toll upon them such as Elijah's depression that found a remedy in basic provision of food and drink (I Kings 17:1-7). The neglect of spiritual needs, such as Saul, who for some reason forgot to feed his soul, can led to losing the healthy spiritual perspective of God in a person's life. Sin was also the cause of depression, clouding the view of God's glory. That was the experience of David, Jesus's disciples, and others. Moses, Elijah, and Job became so depressed at some point in their work for God that they wished they would die (Numbers. 11:15, 1 Kings 19:4, and Job 3:20-21). Tiredness and loss of appetite, another symptom of depression, was experienced by Ahab, Hannah, and Saul (1 Kings 21:4, 1 Samuel 1:7, and 1 Samuel 28:23). Even Jesus himself experienced depression while praying in the garden of Gethsemane (Matthew 26:37).

Ministers are not different from the Biblical characters. Nearly 1,500 pastors leave the ministry every month. This alarming rate of ministers leaving ministry is due to the tension, pressure and stress caused by pastoring (Dance, 2019). Pastoring occasionally

leads to depression or even suicide. Hispanic pastors must implement a different approach in dealing with their own personal mental health issues. Hispanic ministers should understand that admitting the need of help does not make them less spiritual. They are not indestructible or invincible, and they also have limits and bounds as other people do. They are human beings.

Depression, whether mild or severe, is a serious problem that affected great men and women in the Biblical stories. It is also affecting communities all around the world, perhaps more than any other emotional disorder. An estimated 30-40 million Americans, twice as many women as men, will experience depressive illness at least once. Depression is commonly called "The common cold of mental illness" (Rottman, 1986). Ministers in the Hispanic community are experiencing depression even for many years, ignoring that the Bible has something to say about it. In some cases, they are not aware of it and they are not seeking help. Some of them just learned how to suppress or mask any mental disorder with which they may be dealing. Some feel that only praying to God will deliver them from their mental condition, instead of seeking the professional help. This behavior has led some religious leaders to moral failures or even suicide. The results are evident: unhappy ministers, harmed families, and entire communities unable to understand the phenomenon, and even worse, incapable of finding a real answer to this affliction.

Despite what the Scripture says about depression and the evident clinical warnings in ministry, many pastors and other Christians still cling to old myths concerning depression. These are just a few that still find their way into the pews and the pulpit (Hart *Depressed*; Collins):

1. Depression is always due to lack of faith in God.
2. Depression is caused by self-pity.
3. Depression is always due to unconfessed sin.
4. Depression is never the will of God.
5. Depression is God's punishment.
6. Depression comes from Satan.
7. A term like Depression is a contradiction with Christianity.
8. Depression can be replaced by making a choice to be happy.
9. Depression can always be removed by spiritual practices such as praying fasting

These myths are false and oversimplify the dimension of major depressive disorder. Depression is a real issue that requires urgent attention. The Bible has much to say about depression. Choosing the Biblical passages that would be the focus text for this study was a real challenge. Many other Biblical texts deal with depression, and a thorough study would consume many sermons, but Psalm 42-43 gives a solid foundation for examining biblical counsel.

The Treatment of Depression in Psalm 42 and Psalm 43 (NIV)

Psalm 42

As the deer pants for streams of water,
so, my soul pants for you, my God.
2 My soul thirsts for God, for the living God.
When can I go and meet with God?
3 My tears have been my food
day and night,

while people say to me all day long,

“Where is your God?”

4 These things I remember

as I pour out my soul:

how I used to go to the house of God

under the protection of the Mighty One

with shouts of joy and praise

among the festive throng.

5 Why, my soul, are you downcast?

Why so disturbed within me?

Put your hope in God,

for I will yet praise him,

my Savior and my God

6 My soul is downcast within me.

therefore, I will remember you

from the land of Jordan,

the heights of Hermon—from Mount Mizar.

7Deep calls too deep

in the roar of your waterfalls.

all your waves and breakers

have swept over me.

8By day the Lord directs his love,

at night his song is with me—

a prayer to the God of my life.

9I say to God my Rock,

"Why have you forgotten me?

Why must I go about mourning,

oppressed by the enemy?"

10My bones suffer mortal agony

as my foes taunt me,

saying to me all day long,

"Where is your God?"

11Why, my soul, are you downcast?

Why am I so disturbed within me?

Put your hope in God,

for I will yet praise him,

my Savior and my God.

Psalm 43

1Vindicate me, my God,

and plead my cause

against an unfaithful nation.

Rescue me from those who are

deceitful and wicked.

2You are God my stronghold.

Why have you rejected me?

Why must I go about mourning,

oppressed by the enemy?

3Send me your light and your faithful care,

let them lead me.

let them bring me to your holy mountain,

to the place where you dwell.

4Then I will go to the altar of God,

to God, my joy and my delight.

I will praise you with the lyre,

O God, my God.

5Why, my soul, are you downcast?

Why am I so disturbed within me?

Put your hope in God,

for I will yet praise him,

my Savior and my God (NIV).

Exegetical Considerations

Form (Features)

The Psalm 42-43 constitutes a single unit or a single poem and is analyzed as a single psalm. Psalm 42-43 is the first Psalm in the principal division of the Psalter. It opens the second book of the regular division of the five Books of Psalms. It is also the first Psalm of the Elohistic Psalter 42-83 and first of the Korah collection, referring to the Korahites. Similarities are protuberant in terms of language. Also, Psalm 43 has no title or any other superscription and both are incomplete without the other. Three choruses are part of the three general sections: 42: 6, 11 and 43:5. In addition, there is a strong

connection comparing 42:10 and 43:2 with its contexts. Thus, one can say that the entire unit of text is structured as follows: 42: 2-6, 42:7-11 and 43:1-5 (Goldingay, 2007). For the purpose of this study, these sections will be part of the exegesis.

Both Psalms should be considered as a unit and joined as the selected group form of prayer chants of the individual as opposed to the songs of thanksgiving and prayer singing community groups (Psalm 80:5). These groups collect most of the psalms.

Another feature to consider is the description of the afflictions. Dr. Tremper categorizes Psalms into several types, mentioning the three more important Psalms as Hymns, Laments and Thanksgiving Psalms. Psalms 42-43 are framed as a Lament. It is a good exponent of the individual lamentations but with additional features such as temple theology and concrete geographical references as something unique for this type of Psalm. It is a Lament since Psalm 42 is clearly concerned with describing the feelings of the soul that pines for the living God, while Psalm 43 is devoted to describing the pleas. The soul leads the clear emphasis to look for calm and makes a strong call for patience and consolation. Thus, the psalmist looks forward to the time when he can express his gratitude 42: 5,11; 43: 5. The inquiries are sent simultaneously to God and the soul in v.5 and v.10s (Tremper, 2009).

Biblical Context (Historic and Geographic)

Psalm 42:7 indicates that the Song of Prayer (42-43) was written or motivated, by the fountains of Jordan. However, it gives no indication as to why he was praying in that place (43:1), and it gives no details about who was the cantor of the psalm or the precise situation that motivates his song. The scriptures reveal that the reasons for his song are forces who want to kill him (42:7), his need to dress in mourning (42:9 and 43:2), the

feeling that the Lord has abandoned him (42:9-10), and his feeling of being surrounded by enemies who wish evil upon him (42:10). In the midst of his anguish, he is anxious for God's presence (Kidner, 22)

It is likely that the Psalm 42-43 was written before the exile, but there are no valid elements to support that other than assumptions. The Psalmist, after his salvation, took the Psalm to the temple, where it was preserved (40:7) (Kraus, 2009).

Structure

Psalm 42-43's structure is based on refrains that can be divided in two different groups: the majors, which are 42:6,11 and 43:5 and the minors which are 42:4, 11; 42:10 and 43:2. The structure is divided in three sections (Terrien 46; Olofson 63):

1. First Part or Strophe is 42:2-6 Lament I, v.2-5

   Minor refrain A, v.3

   Major refrain, v.5

2. Second Part or Strophe is 42:6-11 Lament II, v.6-11

   Minor refrain B, v.9

   Minor refrain A, v.10

   Major refrain, v.11

3. Third Part or Strophe is 43:1-5, Prayer v.1-4

   Minor refrain B, v.2

   Major refrain, v.5

Each part finishes with a major refrain. Each part develops a movement from despair to hope and awareness of the horrible situation to adds a big portion of declared hope expressed with assurance in the refrain. It is like the refrain is calling the possibility

of future praise, converting it into reality in 43:1-4. In other words, the Psalm begins with longing for God and ends with hope in God. This way of refrain goes through the entire Psalm, exchanging the necessity of longing for God, for God's presence. The proposed questions of when, why, and where, are answered in the end of the unit (Terrien 48).

On the other hand, we can notice that the minor refrains have a thematic connection with the major refrains. The minor refraining predominant question is "Where is your God?" (42:3) His enemies ask the question, and later the Psalmist questions God, "Why, my soul, are you downcast, or why so disturbed within me?" (42:5) In the major refrains, the questions are answered or redirected as "Why are you worried?" (42:5, 11) (Olofsson 45).

A terminological connection between parts 42:7 and 43:4 and the major refrain in 42:6,11 and 43:5, provides positive answers to the exhortation located in the major refrain "to hope in God," "to praise God." Note that these happen again and again in each major refrain (Tremper 90). Repetitions and synonymous expressions are common in Psalm 42-43. The recurrent use of the name of God occurred at least eighteen times, and the expression "to me", occurred at least seven times. This denotes the theme of the Psalm, the relationship God to the Psalmist.

Additionally, the minor refrains B and A stand at the end of the Lament, giving major emphasis: The Psalmist questions God with "Why," and his enemies question the Psalmists with "Where." At the end both questions express the same topic—the Psalmist's weakened relationship with God. As Olofsson deduces: The enemies say it in triumph, but the psalmist says it in anguish (Psalm 197; Olofsson 43).

Title

Several Psalms begin with a title. The Hebrew text assigns a verse to the title but several Bible versions including English translations do not include the title. The original writer of the Psalms did not include titles, but a later editor added them. That is the case of the Psalm 42-43, with the exception that 42 includes a superscription (Tremper 23). *The leader's instruction. The Korahites*. (Lamnasseah) is a term that appears in at least fifty-five of the Psalms, denoting being ahead or driving something. This means a director of music or choir. Whoever leads the music with poetic qualities has more than outstanding skills. Several psalms are attributed to the sons of Coré, but who are they? Originally, the Korahites were a lineage Jorita-Edomite (Gen 36 5ss). They were a special group of the temple in charge of the gates (I Chronicles 9:19; 26:1, 19). Later, they are identified as a group of singers (2 Cr 20:19), and that leads to the deduction that they were the composers of a book of songs (Olofsson 68).

The Text and Commentary

As shown above, Psalms 42 and 43 constitute a single poem that is divided into three sections of strophes. This section discusses each strophe in detail.

First Strophe 42:1-5

The Psalm begins with a comparison marked by a conjunction "as' ', which opens the different metaphor in v.2-4. "As a doe longs for lust or streams, so the wailing pines for Yahweh. Watercourses here are dry stream beds, where any thirsty animal looked in vain for water." (Joel 1:20; Psalm 126:4). The animal faints and cries for the water. Yahweh is the water which quenches thirst and brings sweeping floods. The Psalmist compares the panting of a deer after water, with the way he himself pants for Yahweh. The water is an intuitive picture of the torment and devouring eagerness with which the

Psalmist tends to Yahweh. Kidner saw the Psalmist as envisioning a slower agony of drought. At the end he captures the Psalmist and his torturous thirst after he realizes that the only thing he has is his own salty tears for nourishment (Kidner 165). It is significant to mention that the same contrast is occurring in verse 7 with the overwhelming floods.

The Psalmist uses several questions to enhance his internal dialogue as the struggle between hope and despair continues. In verse 3 he asks, “When can I go and meet with Yahweh?” Certainly, this question is not directed to a particular hearer but is the outpouring of the Psalmist soul and the beginning of his internal dialogue. The way he says it denotes familiarity and intimacy, the thing for which the author longs. Kraus says that the psalmist 's soul faints with desire for the living God, the God who does not participate in the divinities who die. Life knows that it depends on Him. For that God can be found in the Sanctuary and he wonders when the time will be where he can enter the temple and reach the immediate vicinity of His face. The third metaphor found in verse three carries over to verse four describing the psalmist’s torment, saying that tears are his breath. (Psalm 80:6; 102:6). The text doesn’t say what is the cause of his cry. Also, he is mocked by the explicit expression of his tears. But, in spite of the suffering, the Psalmist is surrounded by his enemies who in the middle of taunts and provocations ask him “Where is your God now?” (42.3b). (Psalm 79:10; 115:2; Joel 2:17). It is the typical question that comes from people who do not know God. When Israel or any member of God's people is experiencing a difficult situation, they question God's existence (Olofsson 88; Kraus 667).

The Psalmist now shifted his gaze as he remembered the past worship experience, changing at the same time the Psalms mood as the memory is about joy and celebration.

The role of the Psalmist's memory is to observe the old experiences recalling the happy assurance of his life among the community of God. This is the catalyst that brings a renewed hope in Yahweh. (About the expression "poor out in me", "dentro de mi", please cf. 142:4; 143:4). The imperfect tense conjugation "these things I remember", describes events that are past, and it is the Psalmist who refers to the temple where the community came in procession, singing as they went into the Sanctuary (Psalm 100:4; 118:19s). Kraus says that with memories of those holidays, the psalmist wants to lift his mood and will never forget what he has received from Yahweh. (Kraus 666; Human 29).

Verse five is the first appearance of the Psalms principal refrain "Put your hope in God, for I will yet praise Him, my Savior and my God." To give the Psalm the needed structure, the refrain provides the context for the movement from despair to confidence (Craigie 325). Even though the refrain is repeated in v.12 and 43:5, the formal way of repeating it does not necessarily mean the exact repetition of its meaning (Schokel 16). As the confidence of the author builds throughout the Psalm, its tone changes. It is an internal dialogue and the doubling of himself. This form of doubling greatly expresses the internal tension he is experiencing about God's absence and presence. Ultimately the Psalmist 'struggle is not against God or his enemies but against his feelings and emotions that are taking place in his soul, heart and mind (Clines 726).

Second Strophe 42:6-11(12)

In verse six the prayer begins again, but now it looks more hopeful and describes the gloom of his soul and the disintegration of his vital energy. He was probably referring to an illness, but it is difficult to know for sure. At the start of the second strophe, the Psalmist uses his memory to counter his despair. The Psalmist thinks of Yahweh and his

please refer to a very particular place described in verse six, the land of Jordan. Kraus clarifies that it could refer to the entire mountain chain from Hermon to Paneas. The exact geography appears to be at the head of the Jordan River in the mountains of Hermon in a peak located near the village of Zaora (Kraus 669; Goldingay 27).

Now, why is this land, where the Psalmist's lament takes place far from the Sanctuary also far from Yahweh? From this location the image of torrential waters comes into view as verse seven makes another comparison "Deep calls to deep in the roar of your waterfalls." Whereas water and God were equated with life in verse one, water and life are equated with destruction in verse seven. (Psalm 18:5; 69:3; 88:8). For Schokel these opposite images are significant since they provide a characteristic of a poem: the dramatic tension in the Psalmist 'soul, revealing that the Psalmist has two perspectives about his circumstances. Still, In the middle of the torment, his memories bring the familiar times where Yahweh showed goodness (Schokel 19; Kidner 39).

Verse eight represents the center of Psalm 42-43. The steadfast love that Yahweh sends during day hours derives in a prayer song during the lonely and dark night. Day and Night in verse three is antithetical to verse eight. In verse three, the Psalmist feasted on his continuous tears, but in verse eight he uses his memory to remember that Yahweh is with him day and night by His mercy and the same prayer song He provides. Verse eight should be read as an exclamation for it suddenly interrupts the Psalm and it has been preceded by the deep despair (Schokel, 152). The rhythm of the Psalm is also interrupted by verse nine. Despite the manuscript evidence, Kraus suggests an unavoidable emendation (Kraus 437). Psalm 42-43 is significant in terms of up-and-down progression of thought. Jumps from despair and hope are highly expected. Also, the

Psalm is continually reminding that Yahweh is the source of life (v.2) allowing the Psalmist to move forward from internal conflict, remembering God's faithfulness. The expression "my living God" is evidence for it.

Verse nine says that Yahweh is the Rock (Psalm 18:3; 31:4). He is firm ground amid the waves and destruction. However, this metaphoric expression has an accent of fear and perplexity when it comes to ask "why", "why" in the same verse (Goldingay 29). The Psalmist is sure God had abandoned him in the middle of his torment, while the enemy is still on him. He walks from one side to another with garments of penance and dust (Psalm 35:14; 38:7; Job 5:10; 30:28). Even verse ten reflects that surely, he has the sense of being broken by death. He is experiencing the death in his bones, probably a terminal illness, and while this is happening, he can still hear the voices of his enemies asking him "Where is your God?" (42:3). But it is protuberant that he is still fighting in between his struggles, the awareness that God is trustworthy, and his feeling that God has abandoned him. The Psalmist is using dramatic language to image what he experiences internally. This prepares for the use of the second refrain so that the future hope is stronger than the previous one. The Psalmist knows that the past cannot change. What has God done in it? He brings hope to the present, even in the face of his current torment (Goldingay 30).

Third Strophe 43:1-5

Psalm 42 reaches no resolution but continues through Psalm 43. The third and final strophe is where the Psalmist starts to verbalize his hope as his internal dialogue and lament turn into a conversation with Yahweh (Craigie 328). At this point, guilt is the main factor from the enemies' perspective. The author appeals to Yahweh who is a

righteous judge, and he asks God to intervene. In this second refrain, the Psalmist has roused up enough confidence to request the needed help as he faces the enemies' oppression. Far from his own land, his enemies, unaware of the Psalmist's connection with Yahweh, continue to oppress him. The Psalmist's connection with God constrains people to behave with love. Wickedness and deceitfulness are the weapons of the enemy (Psalm 5:7; 17:1; 34:14; 36:4; 37:1; 107:42; 119:3).

Psalm 43:2 repeats the question that was asked in 42:9 "Why have you rejected me?" However, the author quickly moves to a request for Yahweh to remedy the situation. After, the Psalmist asks Yahweh to send His light and His truth, in contrast to his waves and breakers mentioned in 42:7. He personifies light and truth and asks for guidance to bring him back to Yahweh's presence in the temple. The words "by the holy mountain and the divine dwelling place" clearly show the Psalmist desire to return to the temple. This is the only time that these contrasts appear in the Scripture. In 42:1 the Psalmist requests God to reach out to the earth, but in 43:3 he allows for God's light and truth to act leading him to the destination of God's holy mountain, and God's house and the altar. In 43:4 he declares, "Then I will go to the altar of God, to God, my joy and my delight. I will praise you with the lyre, O God, my God."

The final refrain conducts a more distinctive tone than the first and second occurrence. Even though his situations and conditions did not change, the author's countenance has been transformed, so he can move forward from despair to hope (Kidner 76). The Psalmist is assured of Yahweh's continued presence and love. The time will come when he will once again worship at the temple. The Psalmist wonders to himself, in the context of 42;8 how can he do anything but hope (Olofsson 110).

Theological Foundations

Theological Reflection for the Depressed

The Book of Psalms in the Old Testament is approached with the two questions: How can we find the cause of human sadness? and where do we go to find the God of Israel and the God of humanity? The answer undoubtedly is Yahweh Sabaoth is present in His Sanctuary of Jerusalem, in Zion, the place of God's presence, the Holy Mountain. In consequence, the children of God go to that place, every year in masse to celebrate the great feasts (Psalm 122:1). Those who stay away experience nostalgia during the days of pilgrimage (Psalm 42:4). The desire to get to the place of His presence, urges pilgrims to endure the hardships of the journey. For those who cannot go, this becomes the tragedy of not attending the majesty of the presence of Yahweh. Psalm 42-43 shows a warm, intimate, and friendly look at the "internal struggle" of a person distressing and suffering withdrawal from God's felt presence.

This Psalm, born of the heart, reveals what the Psalmist is longing for deep within his soul. Human beings and the true religion of all time are thirsty for the same thing—the safe experience of the living God. People fully understand the Psalmist's thoughts, knowing that despite the gloomy ravine of his sufferings and struggles, his eyes rise to the heights of life. Considering this interpretive attempt, the question arises of whether it is truly possible to generalize from the perspective of religion, the statements arising from Psalm 42-43. The song of prayer is imbued with the motives of the songs of Zion. All the desire and nostalgia the Psalmist is thirsty for and longs for, are oriented to Zion. He longs for the mountain of God, the Temple, God's people, and the place where God was determined to testify of His presence. The choice of God's place and where His presence

endures, has now been replaced and transferred to Jesus Christ, God's community and God's People in the New Testament. Because of this fulfillment and Scriptural compliance, life and salvation can be found only in the place where God's presence is real in the gathered community (Kraus 671).

Far from the described reality is a consuming sadness. The condition of human beings takes them away from the safe place (The Living God's presence) and also makes their ministry and communities live mired in spiritual poverty, immorality, and anarchy. Only a pertinent word of comfort and encouragement will be able to make them react to what they really need. Only a word such as in Psalm 42-43 can address each person and each community to transform the sadness, depression, struggles and past experiences of salvation into a living exhortation that leads people to wait patiently on their joyful hope.

Why, My Soul, Are You Downcast?

The discussion of whether these two psalms are one single or not, is academically byzantine. The subject is practically the same and both are united by a common refrain of 42:5, 11 and 43:5, "Why, my soul, are you downcast? Why am I so disturbed within me? Put your hope in God, for I will yet praise him, my Savior and my God."

After several attempts to determine who the author was, scholars are not sure who wrote it, but they do know that the Psalmist found himself exiled from Israel where he was supposed to be and from the great worship festivals of God's community. At the same time, his enemies were taunting the Psalmist: "Where is your God now?" (42:3,10). Their oppression (42:9; 43:2) had plunged the author into a deep depression.

Mild or severe depression has affected many people throughout history. Today, major depressive disorder affects our culture more than any other emotional disorder

(Reddy, MS, 2010). The reality of many of the Hispanic pastors is that they suffer in silence the causes of depression, and they are unwilling or unable to seek help. The experience of the community of Hispanic pastors has a close relationship to the reality established in Psalm 42-43. Being a minister is a high-stress job, and in some cases has impossible expectations for success. The pastors do not know why their souls struggle or how to deal with their frustrations, and as a result they turn their frustrations back to themselves. Depression among clergy is as prevalent as it is in the general population, and it is also significantly more noticeable among leading pastors. Other factors such as economical situations, church budgets, and dealing with other people's problems increasingly create frustration and symptoms of depression. Hispanic ministers who come from outside of the country and are immigrants, some with documents, and others without, markedly experience the nostalgia of leading people in their original contexts in their countries of birth. Psalm 42-43 provides hope for them in terms of how the Scriptures relate to the circumstantial reality of this community and provide the needed theological support and spiritual counseling. The Psalmist did not stay depressed. He confronts the depression and seeks God with renewed intensity. The Psalmist shows people how to pull themselves out of the nosedive of depression, no matter how despairing the circumstances are.

The Psalmist admits that he is struggling with depression symptoms that affect his relationship with God, others, and himself (42:5,6; 43:5). He recognizes his emotional condition affected by depression symptoms even though he knows little about them. Some of the Hispanic ministers are dealing with the same circumstances, but do not know

how to deal with their feelings. They do not want to appear unspiritual, weak, or vulnerable. But they cannot deal with it.

The Psalmist mentions his countenance. He experienced symptoms of looking sad or down, losing his appetite, crying (42:3), pouring out his soul (42:4), and being emotionally drained. He felt as if he were in the deep, being overwhelmed by the waves (42:7). The Psalmist feels abandoned and rejected by Yahweh, and he is confused by it (42:9; 43:2) Several of the causes of depression were mentioned.

However, the Psalmist not only recognized the symptoms, he confronted himself asking "why my soul, are you downcast?" Depression can hit a person when he/she comes down from a spiritually enriching experience. The early experiences of our faith wear off and seem to be unreachable again. The Psalmist recalls earlier times when he was enjoying being in Yahweh's house with God's people in procession and great feast (42:4).

The author struggled a lot to get on top of his depression. Psalm 42-43 has four sequences of lament and hope:

1. *42:1-4 * 42:5;
2. *42:6-7 * 42:8;
3. *42:9-10 * 42:11; and
4. *43:1-2 * 43:3-5.

The Psalm makes evident that even if people are down or depressed, they are responsible in an intentional manner to please the Lord by walking in obedience. They must discipline themselves for godliness and pray fervently as the Psalmist did as part of the depression recovery treatment process. If the depressed have God in prayer, there is

hope. Finally, the Psalmist knew Yahweh personally before this trial hit: “My God” (42:6,11; 43:4-5), “The God of my life” (42:8), “my rock” (42:9), also, “the God of my strength” (43:2) and “God, my exceeding joy” (43:4). These verses express an absolute truth that the godly can experience depression. However, The Psalm says that the time to be prepared for a crisis needs to occur before the crisis hit us. The Psalmist spent time with Yahweh and His people before he became depressed. Consequently, he had a strong familiar relationship, a refuge to help him turn from despair to hope. He wanted to appear before his God, to know the benefits of His presence. But he also wanted to praise (42:8; 43:4), and knowing that praise is a command, not a feeling, the Psalmist focused on God’s previous actions with hope that God would repeat His benefits.

Martyn (Jones, 1965) Lloyd-Jones said in his book *Spiritual Depression*: most of our unhappiness in life is because we are listening to ourselves instead of talking to ourselves. Somebody is talking. Who is talking to you? One of the great values of Psalm 42-43 is that the Psalmist is talking to himself, taking himself in his own hands, addressing his issues, preaching to himself, questioning himself “Why art thou cast down?” He continues to exhort himself and condemn himself saying, “Hope thou in Yahweh.” He intentionally replaces the unhappy way of living. He did not end there; he then remembers who Yahweh was and is and what Yahweh had done for him and Yahweh’s people. Then the Psalmist defies himself and starts defying other people, the devil, and the world “Put your hope in God, for I will yet praise him, my Savior and my God” (Lloyd-Jones 20-21).

Psychological Foundations

Major Depressive Disorder Background

Mental illness is a major health issue that affects individuals at an alarming rate (Reddy, MS, 2010). One major category of mental illness is depression, which is an illness of the brain that ranges from mild to severe interruption of thought configurations and behavioral patterns (Dowd, 2004). This phenomenon results in the lack of coping ability when the individual faces the general demands of life and regular daily routines. Depression is a global issue (World Health Organization, 2004). Currently it has third place worldwide on the burden of disease list. Experts refer to depression as "the common cold of mental illnesses" (Seligman, 1995). Major depressive disorder is categorized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Depression is one of the most frequently diagnosed psychiatric mental disorders for the adult population in the United States. (Hart, 2015).

Diagnosis and Criteria

It is very important for this study to distinguish major depressive disorder from grief or bad moods. The signs of depression include depressed mood, loss of interest or pleasure, a feeling of guilt, low self-esteem, appetite problems, interrupted sleep patterns and concentration problems. Clinically, depression interferes with relationships and daily functioning (Lastoria, 1999). The American Psychiatric Association (2013) defines major depressive disorder as:

> Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms are either (1) depressed mood or (2) loss of

interest or pleasure. **Note**: Do not include symptoms that are clearly attributable to another general medical condition.

(1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (**Note**: In children and adolescents, it can be an irritable mood).

(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

(3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note**: In children, consider failure to make expected weight gains).

(4) Insomnia or hypersomnia nearly every day

(5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) Fatigue or loss of energy nearly every day

(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. (DSM-5 p. 160-161)

Also, The American Psychiatric Association (2013) defines the Persistent Depressive Disorder (Dysthymia) as:

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years.

B. Presence, while depressed, of two (or more) of the following:

1. Poor appetites or overeating
2. Insomnia or hypersomnia
3. Low energy or fatigue
4. Low self-esteem
5. Poor concentration or difficulty making decisions
6. Feeling of hopelessness

C. During the 2-year period of the disturbance, the individual has never been without the symptoms in criteria A and B for more than 2 months at a time.

D. Criteria for a major depressive disorder may be continuously present for 2 years.

E. There has never been a manic episode or a hypomanic episode, and criteria have never met for cyclothymic disorder.

F. The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. (APA 160-171)

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is a classification of mental disorders. It is a standard reference for clinical practice in the mental health field. To study major depressive disorder, the last edition of the DSM-5, provides the best available description of how this disorder is expressed and can be recognized by trained clinicians. (APA. 2013).

To be considered a depression disorder issue and meet the criteria for major depression disorder, at least five of the symptoms listed in the DSM-5 must be present during the same two-week period and should represent a change for the person experiencing those symptoms, causing significant distress or impairment in normal social interaction and other areas. Symptoms must not be due to substance use, medical condition, bereavement, or any other mental health issue. The individual cannot have a history of manic, hypomanic, or mixed episodes. Also, those individuals experiencing depression are at an increased risk of developing comorbid mental issues such as phobias, anxiety, impulse control, or even substance abuse (APA 160).

Understanding the DSM-5 Criteria

Depressed mood: One of the symptoms of major depressive disorder is a depressed mood. It is described as feeling sad, down, or hopeless. Some individuals may not be able to describe the feeling or even deny feeling depressed. Individuals may complain of irritability as part of a depressive mood or in addition to it. It is important to pay close attention to posture, facial expressions, and tone of voice, especially if the person is in denial of feelings.

Diminished interest/pleasure: Individuals experiencing depression will notice they are no longer interested in things they used to enjoy. They describe it as something like being unable to experience joy, while others may notice the withdrawal from his or her family and friends, causing an increased isolation. This symptom includes sexual desire.

Significant weight loss or gain: Unintentional and significant changes in appetite are often seen in major depressive disorder.

Insomnia or hypersomnia: Sleep changes are common in Major Depressive Disorder. Individuals wake up in the middle of the night being unable to fall back asleep, while others simply are unable to initiate sleep. Other individuals may experience hypersomnia.

Psychomotor agitation or retardation: This includes agitation resulting in pacing, fidgeting or leg bouncing. Others may experience slowed speech, movement of simply life. Feeling of guiltiness. Also, individuals may negatively misinterpret things said by others.

Difficulty concentrating: Changes in a person's normal functioning include indecisiveness and concentration problems that result in occupational, social, and educational problems.

Recurrent thoughts of death/suicidal ideation: Suicidal ideation is a common occurrence for individuals experiencing depression, resulting in the biggest concern and the worst possible outcome of depression. Statistics show that 0.045% of the general population commits suicide per year (Z. Rihmer, 2010).

Individuals planning suicide generally display certain behaviors. Individuals will talk to someone about it or even give away possessions without reasonable justification. In some cases, mood may seem to improve just before suicide, feeling that the emotional pain and turmoil will soon disappear. Other factor putting in risk individuals with major depressive disorder are: Past suicidal attempts (Rae Jean Proeschold-Bell P. , 2013), alcohol or other substance abuse, comorbid mental disorders, Family history of suicide, and recurrent suicidal ideation (M.A. Oquendo, 2006)

Fatigue: The person has excessive fatigue and lacks the energy to perform daily tasks of living.

Feelings of worthlessness or guilt: Individuals may feel undeserving of the things life has for them.

For this study, major depressive disorder must be understood from the general population to our specific population. Individuals can experience depression regardless of their roles in life. Symptoms are common, with some variation in terms of cultural backgrounds and popular treatments and solutions. In the theoretical study, *Depression: Theory, Assessment and New Directions in Practice*, E. Thomas Dowd describes the

phenomenon of depression and discusses the nature and origins of depression. Dowd says that depression consists of five basic common expressions: emotional, motivational, cognitive, vegetative, and physical, and delusional having only the emotional manifestation as the one we think of as depression. Three levels of cognition are considered important elements in evaluating the presence of major depression disorder: cognitive distortions, characteristic self-statements, and core cognitive beliefs. These are discussed in this study (Dowd, 2004).

Predominance: The National Institutes of Mental Health considers that more than eighteen million adults in the United States of America are experiencing depression each year (NIMH, 2003). In average and during their lifetime, one out of every eight men and one out of every five women experience major depressive disorder, and at least 25% of those do not seek out help of any kind (Kessler, The National Comorbidity Survey of the United States, 1994). Part of this statistic is because depression remains stigmatized among the general population (K.M. Berkins, 2003).

Depression is a growing cause of disability, and it is estimated it will be the second leading cause of it by 2020 (C. M. Michaud, 2001). In fact, the prevalence increases and occurs at younger ages, and despite all the propaganda and campaigns to encourage people to seek help and treatment, the problem remains in place (R.D. Goldney, 2002).

Etiology: A lot of theories try to conceptualize how various factors such as genes, early family interaction, educational processes, cognition, and social environment work interact to produce depression. Frequently, depression results because of a traumatic event or loss (Kessler, “The Epidemiology of Depression”). However, it can be the result

of career disappointments or an interruption in social relationships. Genetic components seem to be linked to a family history of depression or anxiety (S.H. Goodman, 2006). These theories have different perspectives to view depression. However, most of them take into consideration the biopsychosocial theory of depression, which assumes social, biological, and psychological aspects (Lastoria, 1999).

What Causes Depression?

Major depressive disorder is caused not by one element but by a combination of factors interacting with one another. Depression can affect anyone despite their age. It is not easy to understand how depression works as a mental disorder. Many people who have it do not understand why some people are experiencing it and others do not. Understanding how a disorder works enables a person to cope with the disorder. Understanding the causes gives a better perspective of the symptoms and facilitates treatment before the disorder takes over.

A few causes increase the possibility of someone having depression. In some cases hormonal changes or genetic factors trigger depression. In general, abuse, whether emotional, physical or sexual, even if it is a past experience, can cause depression later in life. Individuals who have biological vulnerability to depression can develop it while they are experiencing personal conflicts in their social relationships. Major events in life can lead to depression, and they may be either bad or good events. Some individuals who take responsibility for the bad events but not for the good events are predisposed to experience depression. Changes in life or personal problems may provoke depression as well. Death events or losing someone and having sadness over the loss is natural but it can lead someone to develop depression as well.

Some modern causes such as job related stress and the accumulation of work and responsibilities trigger depression at unexpected levels. Stresses such as these result in financial worries, marriage difficulties, parenting, unemployment, and other events. Some people may stake their happiness on achieving specific goals in life. If for some reason they have failed, this sense of failure increases depression.

Common Causes of Major Depressive Disorder in Ministry

Despite decades of research, no definitive cause for major depressive disorder has been identified. Researchers have sought to explain the connection between individuals and depression. When it comes to determining causes, work related stress and an environment that produces fears of failure creating negative emotions could lead to negative psychological problems. Only a few researchers have studied the physical and mental areas of the clergy even though they are a sizable occupational group. The United States Department of Labor (2012) estimated in 2010 that there were 230,800 clergy of all religions, with a predicted growth rate of 18% by 2020 (Rae Jean Proeschold-Bell A. M.). The article, *Clergy More Likely to Suffer from Depression,* Duke University also analyzes factors that make members of the clergy more susceptible to depression. Those factors are strongly related to work environment and isolation. The article proposes firsthand evidence for the causes and manifestations of depression across some religious groups. Also, this material examines what the perception is in terms of mental health issues in the pastoral community (Rae Jean Proeschold-Bell A. M., 2013).

The factors and triggers causing major depressive disorder can be numerous and even though there are common factors, it also depends on an individual's environment and cultural characteristics. Andrew Knott's article provides a list of the prominent

factors producing depression in ministers: failure, the fear of failure, rebellious opposition, disappointment, mental and physical fatigue, loneliness, stress (caused usually by finance), frustration, accumulated hurt and anger, and unresolved inner issues. This is easily accessible information that can be compared with scientific information and literature. Notwithstanding that it is condensed, Knott's information is beneficial for this study in terms of obtaining an easy understanding of those factors and triggers (Knott, 2014).

When it comes to religious and spiritual factors producing depression, Bonelli and other authors in their Journal, "Religious and Spiritual Factors in Depression", discover several elements through case studies of individuals experiencing depression and using their religious backgrounds as a support measure. This document also examines how religion and spirituality can cause depression. Religious beliefs, traditions, and rigid administrative and organizational structures may increase stress, guilt, and lead to discouragement as individuals involved in ministry fail to live up to the high standards of their religious tradition and structures. It is also significant for our study that this book highlights specific scientific information that is relevant in the process to determine factors of major depression (Raphael Bonelli, 2012).

Determining the most common causes that contribute to the growing problem of major depressive disorder among clergy and pastors of the Church of God Southeast region Hispanic Ministry requires additional analysis. The role of religion and spirituality related to symptoms and causes of depression in ministry is examined in the article, "Barriers to the Recognition and Treatment of Depression" by Bryant. This document recognizes that religious tendencies such as traditions, roles, and beliefs may increase the

possibility of having depression symptoms and experiencing guilt and sadness and lead to discouragement. The pastor vocation is also potentially fraught with high levels of relational stress. Religious organizations and churches vary in their expectations of pastors. Most of the time these expectations are very unclear. In most cases, pastors are typically the leaders of all activities. At the same time, pastors are positioned to respond to the emotional needs of congregants and are expected to respond even while they need to move work agendas forward. Additionally, the church context varies. Some churches are struggling and shrinking, while others are thriving and expanding. Inserted in that situation, pastors must respond to all kinds of additional expectations of the church. Those factors can contribute considerably to the pastor's willingness to admit or deny depression symptoms and the tendency to seek or refuse professional help. Bryant's document highlights the stigma surrounding depression and the barriers to openly discuss it, in detriment of any intent of treatment or approach to overcome it (Keneshia Bryant, 2013).

Roles of ministry are an interesting set of circumstances where the combination of ministry responsibilities can lead an individual to an increased risk of depression symptoms. When it comes to identifying those roles, Blizzard mentioned what he calls the six practitioner roles of any preacher, priest, pastor, teacher, organizer, or administrator working in ministry (Blizzard, 1956). The first one is the role of **ritualist**, where the pastor administers baptisms, and facilitates other rites such weddings and child dedications. The second role is personal **interaction.** Pastors should have one-on-one with congregants, including the counseling processes and visitation to sick congregants. In fact, pastors spend an average of one-fifth of their personal time providing pastoral

care (Carroll, 2006). The third role is being a **preacher**. The pastor should communicate with the congregation to guide them and inspire them. Fourth, they are **teachers**. The pastor should be involved in the preparation of teaching curricula and other educational programs and sermons in addition to worship. That takes at least one-third of their regular working time (Carroll, 2006). Pastors are also **organizers**. In their fifth role, they should be a **facilitator**, promoting activities inside and outside of their congregation, getting involved in community events and activities. Finally, Blizzard mentioned the sixth role as **Administrator**. Pastors should constantly oversee church leadership, building, budgeting, and committees (Blizzard, 1956).

It is obvious that pastors navigate difficult situations all the time. They are the first responders in a critical situation (A.S. Bohnert, 2010). Those responsibilities create a very busy day for pastors and a fragmented life with just a little bit of predictability. Being a pastor is having a vocation fraught with relational stress. Additionally, churches are not always clear enough about their expectations for their pastors. Ministers are positioned to respond to almost all emotional needs of their congregation even while the pastor is trying to move the church agenda forward. At this point, it is appropriate to consider what Cameron Lee and Judith Iverson-Gilbert mentioned as the four essential stressors in ministry: family criticism, boundary ambiguity, personal criticism, and presumptive expectations (Lee, 2003).

Three aspects surrounding ministry and the pastor's occupation potentially serve as triggers of depression. The first aspect is that pastors feel called by God to their career (Campbell, 1994). This includes the deep personal sense of desire to serve God through ministry. However, this sense of serving God is not enough because the church must

affirm the pastor's calling, suggesting to the congregation that this person would be a good pastor. Here, the pastor should believe that he or she possesses the needed requirements to become an effective pastor. This call fills the pastor's work with personal spirituality and intensifies the stakes of perceived failure (Mahoney, 2005) (Stewart-Sicking, 2011).

The second aspect is that pastors and ministers at church face high expectations for their behavior from their communities that perceive them as holy people and assume that they as pastors do not need spiritual, psychological, and other support. Also, pastors avoid confiding in others about problems based on fear of creating unneeded tension in the community. Carroll says that clergy have very few or no confidants (Carroll, 2006).

The third aspect is the experience of extreme levels of negative and positive affect. It is a paradox, but pastors may suffer depression while also feeling a strong sense of satisfaction because of what they do. This is basically the result of fulfilling their job-related responsibilities and is like experiencing joy in a wedding and grief in a funeral the same day or week.

Treatment

This research focuses on two commonly chosen treatment modalities for major depressive disorder: Psychotherapy and antidepressant medication.

Psychotherapy

It is difficult to define and compare different approaches because they are extensively numerous. In 2008, Cuijpers, Anderson, Van Straten and Van Oppen published a meta-analysis where they compared seven out of the most commonly psychotherapeutic approaches. Included were behavioral therapy, cognitive therapy,

problem solving therapy, interpersonal psychotherapy, and nondirective supportive therapy, and others. Precisely 2,757 individuals participated in the 53 studies. The results of this study were unpredicted. The efficacy of some of the most important types of psychotherapy in terms of results were very insignificant. A slight advantage in the interpersonal psychotherapy may have made the small difference. This research describes only three types of the most common approaches derived from the literature.

Cognitive Behavioral Therapy (CBT) and Cognitive Therapy (CT): CBT has its foundation in the idea that thoughts cause feelings and then behaviors, instead of external aspects such as situations, events, or people (Beck and Rush, 1979). Cognitive-Behavioral approaches effectively present a rationale for depression and treatment, defining it with an appropriate vocabulary for the description of the problem (Antonuccion & Danton, 1997). Both approaches educate individuals in terms of how thoughts, feelings, and self-monitoring skills relate to each other, providing a clear plan for self-control and change. Both provide feedback and support, teach skills for personal effectiveness and independence, use positive reinforcement and relapse prevention strategies (Seligman and Reichenberg).

Interpersonal Psychotherapy (IPT): IPT concentrates on the clients' history of interactions with others, the quality of those interactions, cognition about themselves and their significant relationships and the associated emotions (Seligman and Reichenberg 190). The process starts when the individual experiences a crisis. Then, the person attempts to handle the crisis, being influenced by their biopsychosocial vulnerabilities. This is what is called the "interpersonal triad." The third side is the social support which is

the setting in which the stress-biopsychosocial vulnerabilities interaction occurs ("Overview").

There are similarities between IPT and CBT. They are both a brief and focused treatment with emphasis on the therapist-client relationship. The role of the therapist is to be a supporter and an ally. IPT focuses on interpersonal problems causing distress and works with symptoms resolution, functioning improvement, and the increase of the quality in terms of social support (Overview).

Behavioral Activation (BA): Behavioral activation was developed in the 1970s as a treatment for depression. It emphasizes the function and purpose of the individual's behavior. An individual experiencing depression is often recognized by the loss of certain activities with an increase in avoidance including crying, complaining, and irritability. "Depression is a passive style of responding, which leads to avoidance of difficult life issues" (Houghton, Curran & Ekers 2011). Also, individuals are permanently receiving reinforcement from other individuals around them, resulting in an intensification of depressive behaviors.

BA's treatment breaks the cycles of avoidance through increased activation. The process starts with the identification and encouragement to engage with activities and context that reinforce the individual long-term life goals (Dimidjian, 2006). Examples of these therapeutic strategies include creating a schedule for each day, self-monitoring, assessment, and treatment of behavioral issues, and implementing structure into the daily schedule.

Antidepressants and Medication

A common treatment for major depressive disorder is the antidepressant medication. This pharmacological intervention is not curative but provides symptom relief. However, there is no evidence found in the scientific investigation that antidepressants help to prevent future depressive episodes once discontinued (Leventhal and Antonuccio). Now, according to DeRubeis, an individual discontinuing medication has from three to five times more risk of recurrence than others (DeRubeis, 2008). Consequently, physicians frequently encourage clients to remain on medication for at least six months or indefinitely.

It is very important to understand in detail major depression disorder and the treatment routes. There is a gap between the efficacy of antidepressants shown in the general population and the reported results in clinical trials. The rate is that up to 40% of individuals fail to improve their condition using antidepressants for the first time (Arroll, 2005). This may happen because of the lack of time that physicians can devote to clients or because they are not properly following the guidelines when prescribing (Wade, 2006)

As other medications, antidepressants have side effects. It is estimated that around 70% of primary care patients are not using their medication treatment anymore due to unwanted effects (Nurnberg, 2003). A post study of a group of 401 participants using antidepressants, found that at least 86% of the participants reported side effects by the 3.5-month rank. In the same group, 55% were discontinuing the medications (Hu, 2004). The most common side effects include headache, appetite and weight changes, nausea, sexual disfunction, jitteriness, and insomnia. Those side effects can also be used

positively. The antidepressant, Wellbutrin, can help to increase the energy levels in an individual who is experiencing fatigue and is lethargic (Bostwick, 2010).

For those that prefer antidepressant treatment, around 50% of individuals experiencing major depression will respond positively to any antidepressant. The other 50% improve their conditions to a combination of medication (DeRubeis, 2008).

Antidepressant therapy has significant benefits. A meta-analysis study, completed by Arroll et al. in 2005 compared 15 studies, including selective serotonin reuptake inhibitors, tricyclic antidepressants, and both to a placebo. The results shown that both medications are more effective than placebos when treating major depressive disorder and other types of depression (Arroll, et al. 2005).

How Do Hispanic Pastors Traditionally View Major Depression?

Even though the aspects mentioned previously are common in different Christian organizations around the world, studies agreed that roles, time use, and job demands are similar across Baptist, Methodist, Lutheran, Pentecostals (Church of God Hispanic Ministry southeast region), and other organizations (Carroll; Dewe; Shenan). These studies and articles span several geographical places including the US. Even though the researchers provide statistical data regarding the U.S population and they do not exclude the immigrant population, this study adds material to the lack of specific data about Hispanic pastor's population.

Added to the list of causes of depression are other factors that specifically affect Hispanic pastors, including those from the southeast region of the Church of God. These factors include the physical and mental fatigue experienced from having an extra part time job or full-time job in addition to the ministry. The average salary received by

Hispanic pastors does not match or compensate them for the work they do as pastors. This situation makes the pastor seek another source of income to fulfill his family's needs. Another circumstance related specifically to Hispanic pastors is going through long immigration processes that limit their chances of establishing a stable life in integral way. These processes have other effects, such as lack of health insurance, lack of equal opportunities for themselves and their families, and even the uncertainty of being imminently deported. These circumstances, together with the inability to handle adversities in a healthy manner, are factors that determine the potential risk of falling into depression while doing ministry.

Assuming a healthy attitude toward the phenomenon of depression is important. The *Journal of Primary Prevention* produced a PDF article where United Methodist clergy in North Carolina, including some Hispanic pastors were surveyed via telephone and personal interview. The survey explored depression and anxiety symptoms. The results provided a reference of diagnosis and prevention programs directed to pastors, ministers, and the leadership population. The *Journal of Primary Prevention* highlighted the survey's results to reinforce the importance of having an organized system to deal with depression symptoms. The article concludes that due to the high rate of pastor depression signals, the need for preventive policies and programs for the pastors is evident. The full article uses effort-reward imbalance theory to understand high rates of depression and anxiety among clergy (Rae Jean Proeschold-Bell P. A., 2013).

To delineate the specific stressors in a stressful work environment and health outcomes, the theory of effort-reward imbalance postulates that high effort paired with low reward leads to emotional distress and poor health outcomes (Siegrist, 1996). Among

Hispanic ministers, the stressors are extrinsic and intrinsic demands with the absence of rewards. The pastors do not deal with those stressors in a proper manner. High workload without resources to do the pastoral work, structural role conflicts, high responsibilities, perfectionistic thinking, inability to get away from work responsibilities, needs for approval, money, and many others are some of the stressors Hispanic pastors are not dealing with, resulting in ministers living in depression. Therefore, it is extremely important to implement an internal organizational structure to deal with the problem of depression.

Recently, some church organizations have wakened to the reality of depression. David Benner's study "*Strategic Pastoral Counseling"* provides a short-term structured model with a perspective on how pastoral counseling is carried out. The study concludes that the conventional and religious methods need to be more sensitive to the ministers and pastors' beliefs. Unfortunately, the reality in the context of Hispanic pastors living in Florida, experiencing major depressive disorder reflects an extremely poor structured recovery program. A basic clinical recovery program does not exist for those pastors undergoing counseling because they are experiencing depression symptoms. Instead, lots of stigmas surround them all the time. Benner's book is the synthesis of what in general terms is offered to pastors. Popular pastoral counseling and spiritual direction seems to be good enough in the context of the church. However, important clinical elements required for an accurate diagnosis and treatment are lacking. Benner proposes a guideline to provide therapeutic help and provides significant information to this study without sacrificing scientific knowledge and the accurate understanding of major depressive disorder issues (Benner, 2003).

Role of Hispanic Pastors in Treatment

In general terms, individuals struggling with mental health issues do not seek out mental health professionals. Instead, they first turn to others for support (Hohmann, 1993). This phenomenon is deeply rooted in the Latino culture. In Latin America, in general, the codification of mental health problems is very recent and has been adopted from other countries more developed in this area. The Latino's population is not only not seeking clinical and professional help, but also place pastors and ministers on the frontlines as mental health workers for society without the proper preparation (Weaver et al.).

Pastoral care or assistance to those individuals experiencing mental health distress in the society was one of the tasks of the Christian church many years before the arrival of the modern psychotherapy (Jhonson, 2000). Later in the nineteenth century, secular and sacred disciplines became at odds in their observations and approaches to identifying and treating mental health problems. Freud (1959) found similarities in neurotic obsession and religious belief, saying that most of those religious ideas are deep-rooted in wishes and illusions. Other secular practitioners throughout the last century, such as Vetter (1958) and Skinner (1953), expressed the same perspective, reducing Christian beliefs to reinforced rituals.

It was not until 1956-1957 that the USA's Congress established the Joint Commission on Mental illness, to evaluate the available resources to address the problem. Part of the Commission's work was to create a nationwide survey. The survey results were as follows: Who sought help for emotional issues? Forty-two percent of participants aswered that they make contact with a minister (pastor). Twenty-nine percent contacted

their physician and twenty-seven percent contacted a mental health professional (Gurin, 1960). A few years later, the study was replicated and in 1976 the percentage of individuals who contacted a pastor remained high, at 39%. Pastors still have a very relevant role in terms of mental health. Even though, among Hispanic countries, it is difficult to find comparative statistics like those above, the reality of these statistics is the reflection of a worldwide tendency showing who individuals seek for help when the need it.

What happens when the pastor is the one who needs help? The first option is always the self care. When it comes to seeking help, rooted in the mind of Hispanic pastors and ministers is the tendency to to continue praying and seek support from another pastor instead of a mental health professional. The problem is that the clergy are not trained to treat mental health issues and opt to hide behind religious excuses. Pastors and ministers want to be seen as unshakeable and do not allow anyone to see what they are going through, much less expose their problems to other pastors. Instead, they keep working and hiding under a customized spirituality, seeking to be seen as indispensable and productive.

For those pastors that take the step forward, the same options are available to them that are available to other individuals. A huge number of ministers still view depression as a weakness, but it is a disease. Many churches view their pastors as strong and stable shepherds, but the reality is that they are experiencing a large disconnection between the image they are projecting and the emotional battles that they are fighting. Even pastors with a good sense of self are vulnerable to experience themselves being shaken.

When it comes to analyze how Hispanic pastors approach major depression, Bryant and other scholars like Greer-Williams, Willis, and Hartwig recognize that the religious inclinations can significantly contribute the willingness or unwillingness to admit depression and the tendency to seek or not seek help. The study of "Barriers to the Recognition and Treatment of Depression," has a valuable the analysis of the role that religion plays in terms of symptoms, treatment, and causes of depression in the United States. This document highlights the stigma surrounding depression and the inability to openly discuss the issue. Instead, they believe that there is phobia where pastors do not want everything to be known about them. This reluctance ruins clinical or similar intervention methods (Bryant, et al. 2013). Pastors have lived in the depression environment for such a long period of time that they do not know they are down. They believe that admitting depression is synonymous to admitting defeat and weakness. They act behind a mask, pretending to be something that they are not.

To understand better how different religious groups, assume psychotherapy, Larson McCullough's article provides a guideline reflecting how mainstream Christian communities perceive mental health issues and how churches are willing to accept psychotherapy and clinical methods of intervention when ministers and pastors suffer depression symptoms. The document highlights the view that some pastors think that depression is due to supernatural causes. If they talk about being depressed, they think they will be labeled and that makes them stay underground. The article gives additional information describing and consolidating the scenario of how Christians Pentecostal Churches have traditionally handled circumstances when a pastor or leader experienced

major depressive disorder. The same is true for many Hispanic pastors (McCullough, 2015).

Archibald Hart is a senior professor of Psychology and has a well-known ministry to Churches through psychological training, consultation, and education. Hart analyzes current popular methods pastors use to deal with depression, such as spiritual counseling, confiding in friends, or pastoral counseling. The author describes some comprehensive methods of how pastors who take the step forward generally are coping and caring with major depression disorder. The recognition of depression is the first step. Second, the trigger must be identified. The pastor is far better off knowing what iss going on than not knowing reality. Ministers need to face their reality and understand the cause of their cause of depression. Finally, pastors should learn from their depression. Hart wrote other books about depression which give a clear perspective of how to heal and help others.

Can a pastor keep on doing their pastoral work during a major depression episode? It depends on the severity of the depression. Some pastors live in crisis, experiencing severe depression, and they do not perform their work well. If that is the case, it is vital to get into treatment as soon as possible. Hart's book *An Inventory for Measuring Depression. Archives of General Psychiatry* gives insight and a better understanding of how depression works (Archibald Hart, 1984).

Hart's article gives first-hand accounts by pastors and ministers who have suffered from depression. It provides valuable material on the direct relationship between the likelihood of depression, tension, stress, and burnout and the ministerial work. The book is one of the most recent research articles, presenting immediacy to the information through a contemporary perspective (Hart 2015).

It has been difficult to find specific information and statistical data about levels of depression in the Hispanic population that lives in the United States. Even less information is available regarding Latino Pastors suffering from depression. Statistical information includes the Latino population within the general population, but there are very few studies aimed specifically at the population.

How to Determine Who Is and Who Is Not Experiencing Depression

For this study, the valid instrument to determine who is and who is not experiencing major depressive disorder is the Beck Inventory for Measuring Depression (Beck, et al. 1967).

Aaron Beck and Brad A. Alford's book, *Depression: Causes and Treatment*, proposes a comprehensive survey of all aspects of depression. The Beck survey perspective is considered definitive in this study. In preparation of future action proposal, it contains a broad review of theories, symptomatology, biology, and treatment processes of depression. Based on his own experimental findings, Beck and Alford have synthesized a new approach to depression that provides the rationale for the cognitive therapy of this disorder. This can be considered for a future action plan for this population (Beck and Alford).

"An Inventory for Measuring Depression" describes the development of an instrument designed to measure the behavioral manifestations of depression. An appropriate system for identifying depression must be established for this study, and to test psychoanalytic formulations of depression, this report helps evaluators not to depend only on the clinical diagnosis theories but to have a method of defining depression that is reliable and valid. (Beck, et al.,).

It is necessary to focus on the psychometric properties of the Beck Depression Inventory II, to support the value of the test, which analyzes both psychiatric and non-psychiatric samples reviewed in a five years' frame. The results indicate that the BDI II is a reliable and valid measure of depressive symptoms across racial groups. In the past decade, research has spawned high interest in ethnic and cultural differences in depression, pointing to the possibility of similar characteristics of depression as measured by BDI II across those cultural groups, where a variety of Hispanic cultures exist (Dutton. GR, 2004). The main idea for this study is to have a perspective of how the validity of the BDI works with respect to clinical ratings. Beck, Steer, and Garbin provide evidence that the BDI is applicable to various subtypes of depression (Beck, 1988).

When examining a group of pastors and ministers that have not been exposed to a potential uncomfortable situation such a psychological test, the examiner must consider the potential variations during the test. To avoid an uncomfortable situation a brief explanation and additional pre-test instructions were given. Part of it was the inclusion of some stories of pastors who went through depressive journeys. Robertson in his book *My Journey through Depression: A Pastor's Story*, provides first-hand information from a representative of the clergy, "*A Pastor's Story*" was crucial and essential for a subjective approach to the topic. The main purpose was to help the participants to understand the importance of assume a healthy position toward the phenomenon of depression among minister's population. The researcher used this book and its information very carefully, due to its subjectivity. Some of the material may not be 100% accurate, but Robertson's book adds valuable information from other pastors who are coming forward and talking openly about depression (Robertson, 2011).

In the process of integrating the collected information from the BDI II into a useful psychological report, different samples report from different settings were reviewed. In the *Handbook of Psychological Assessment*, a complete reference work on psychological and psychiatric assessments, Groth-Marnat explains the principles of assessments, evaluations, questionnaires, and report writing (Marnat, 1990). Essentially, this manual has provided the needed guidance to select and administer the BDI test, shown how to interpret and assess data and demonstrated how to integrate the test scores as well as additional information when writing reports. It gave a sense of the breadth of assessment.

This study focuses on the BDI II test for the assessment process, but it does not develop a treatment plan. It takes into consideration how Hispanic pastors are currently dealing with the depression problem and makes an assessment to provide a better perspective of where Hispanic pastors are in terms of depression. The group selected for this study was examined superficially and asked whether the interaction between coping and cognition predicts changes in depressive symptomatology. Renaud's study is a good point of reference suggesting among others, that engaging in specific types of adaptive coping strategies and avoiding maladaptive coping may be important in predicting the level of depression for individuals who have high levels of certain cognitive errors (Renaud, Dobson, and Drapreau).

Research Design Literature

The literature review plays an important role in analyzing and supporting the existing information. It assists the researcher with the clarification of thoughts and concepts about the study, helps establish the outline for the presentation and analyses of

findings. Also, it provides foundation for the relevancy of the study and value of this research.

Writing a dissertation requires a strategic plan for conducting the research project. This plan demands a research design which requires choosing a topic, developing research questions, outlining the steps for conducting the study, organizing the research, and reporting it. The literature review aids with the project.

The purpose of this study is to describe the presence of major depressive disorder in Hispanic pastors of the Church of God in the southeast region. The goal is to understand the most common causes and symptoms that would provoke a Hispanic pastor to become depressed and prepare the road to devise a plan of action with alternatives for dealing with the problem in the most appropriate manner.

Most of the books and articles that discuss the problem of depression in the clergy use qualitative research that leads to conclusions about depressive behaviors linked to the church. Literature that is related to the theological foundations of depression focuses more on the causes and symptoms of depression. Psychological studies use quantitative figures but have limited information for depression in pastors and ministers. Psychological research only mentions the probability of ministers suffering and being diagnosed with major depressive disorder. Based on the literature review, this study uses quantitative data at a low profile, because pastors are unlikely to admit depression symptoms in a society that stigmatizes them.

The methodology uses mixed methods since it combines the quantitative and qualitative approaches to the study (Creswell, 2003). Both methods collect and interpret the data. The quantitative approach interprets the answered questions using statistical

analysis and the answer's descriptive design to acquire accurate, factual, and systematic data. The qualitative approach explores major depressive disorder as mental health issues, identifying the most protuberant symptoms and themes within the data. One of the advantages of this method is the data collection.

In detail, the fundamental literature for the purpose of this study is focused on the descriptive research methodology. According to John W. Creswell, the cross-sectional survey is effective for working with values, beliefs, and attitudes. Cross-sectional surveys can be conducted at a low cost and use a short period of time (Creswell).

The project used a brief demographic questionnaire as an introductory part of the assessment, indicating the knowledge, the existence and regularity of depression symptoms and the Beck Depression Inventory test II. The information was compared and related to insight drawn from the literature review and used for qualitative analysis. The pattern used in biblical-theological literature is the application of qualitative methods, which mention depressive habits in ministers and pastors but without supporting data. Instead, the referred psychology documents and papers provide quantitative data but not rationalized with qualitative information. This is the main reason the literature review of this study used both methods (qualitative and quantitative in a low profile) to support each other.

This study considers different factors deducted from literature review. The participants' responses vary according to their underlying ideologies, and the researcher needs to assess the differences. Some pastors are more liberals and others are more fundamentalist, and they provide different answers based on their ideological backgrounds. (Larson; Meylink and Gorsuch; and Mullica). In separate articles they

propose compensating for the differences in the responses by coordinating face to face interviews which according to them yielded an accurate 75% response rate.

Another factor is the familiarity of some of the participants with the diagnostic terminology (Meylink, 1988). To compensate for the differences in understanding the terminology and differences in knowledge, the researcher should instruct the participants before starting, review the information, and respond to questions if necessary.

Summary of Literature

The literature reviews discussed numerous biblical, theological, and psychological sources on the topic of depression, primarily in relation to pastors. Literature from the Bible, published books, theses, scholarly journal articles, and internet sites supported the research project.

The literature about depression is extensive, and the studies continue to show an interest its causes and effects in the life of people involved in ministry. While researchers have generally agreed that pastors are at risk to experience depression, they do not agree that pastors share the same causes of depression as other individual not involved in ministry. This literature review also demonstrated that internal and external factors contribute to depression. Those factors combined with the lifestyle and pastoral duties of ministers contribute to the presence of major depressive disorder among Hispanic pastors and ministers in general. The biblical, theological, and psychological support in this study addressed the gap in literature regarding to the relationship pastors and depression.

CHAPTER 3

RESEARCH METHODOLOGY FOR THE PROJECT

Overview of the Chapter

The purpose of this chapter is to present the methodology of this cross-sectional study, which was designed to understand the issues and causes of depression among Hispanic pastors. The chapter contains the nature and purpose of the project, a restatement of the research questions, description of the sample population and general information about participants, followed by the criteria for the selection of participants. It will address the procedure for collecting and analyzing evidence, and a description of each measure or instrument that was administrated, followed by a reliability and validity section. Ethical considerations are reviewed as well.

Nature and Purpose of the Project

The purpose of this study was to identify factors that contribute to the presence of major depressive disorder in Hispanic pastors of the Church of God Southeast Region, and its impact on their ministries, in order to make recommendations to address this problem.

Research Questions

The study used four different research questions. The researcher formulated the questions, with the intention of securing prompt answers that would address concerns about major depression disorder affecting Hispanic pastors. The questions are the result of the original idea that motivated this study, the literature review, and the study process. The research questions were supported by the responses of the participants. As a result, the research questions were reaffirmed as the guide for the study. The questions enabled

the researcher to conduct and conceptualize major depressive disorder outside the margins of clinical descriptions and expectations. To fulfill the purpose of this study, participants answered the following questions, and the researcher tested the related hypotheses.

RQ #1. What are the most common symptoms of major depressive disorder among leading and non-leading pastors in the Church of God Hispanic Ministry Southeast Region?

The study includes established procedures for the purpose of understanding the most common symptoms of the problem. To answer this question, the researcher used the Beck's Depression Inventory test as the instrument to collect the needed data. Question 23 of the questionnaire was also used to identify the most common symptoms in major depressive disorder in this population. The questions are in Appendix A.

RQ #2. What are the most common causes that contribute to the growing problem of Major Depressive Disorder among leading and non-leading pastors of the Church of God Hispanic Ministry Southeast Region?

The instruments used to answer this question were Beck's Depression Inventory II Test, and question 22 of the questionnaire. Both the questionnaire and BDI are in Appendix A. The questionnaire included sections pertaining to demographic information, such as gender, race, level of education, marital status, experience in counseling and years involved in ministry. The collected data contextualizes the respondents without compromising the objectivity of the researcher who analyzed the collected information. This process supported the intent to be as accurate as possible and to determine the

common causes that contribute to the problem of major depressive disorder among Hispanic pastors.

RQ #3. What are the most typical and popular non-formal approaches this population use to deal with depression symptoms?

To determine the most common and non-formal approaches used by Hispanic pastors to deal with major depressive disorder's symptoms, the questionnaire used questions 10, 13-14, 20-21 and 24. It requested participants to offer responses that highlighted their attitudes and confidence towards seeking non-formal help or professional help when dealing with major depressive disorder and revealed their confidence or non-confidence in mental health professionals compared with non-formal approaches.

RQ #4. How does the severity of Major Depressive Disorder affect the life and ministry of pastors of the Church of God Hispanic Ministry Southeast Region?

To determine the severity of the problem affecting the life and ministry of pastors of the Church of God Hispanic Ministry, the questionnaire used questions 11-12, 14-18, and 25-26, to provide an accurate panorama of answers. These research questions required the most intentional objectivity on the part of the participants.

Ministry Context(s) for Observing the Phenomenon

According to Suburban Stats statistics, in Florida, 4.226.803 out of the 18.801.310 habitants are Latinos (Suburban Stats, 2019-2020). The statistics are related to citizens and legal immigrants. Besides that, Florida has one of the highest levels of illegal immigration of the United States (Newsmax.com March 27th of 2018). Some of the Hispanic pastors belonging to the Church of God Hispanic Ministry in the Southeast

Region might be part of the non-documented population. Even though they are considered a minority, each person comprehends and experiences his or her legal status in different ways. Sometime this is a cause of depression among the Hispanic population. This study did not ask any questions related to legal status because it did not represent a significant variable.

The participants were a multicultural Latino group of 439 ministers, living in Florida. Thirty-six out of those 139 ministers were senior pastors working in a local church in their communities. The other 103 clergy were licensed ministers who were not pastoring but were developing a diversity of ministries, supporting other churches or were co-pastoring.

Aside from its leadership and operational structure, The Church of God Hispanic ministry in the southeast area located in Florida has reported individual ministers who experience depression. For this reason, the denomination has a significant interest in depression and wanted this researcher to investigate depression and its manifestations.

The sample population for this study is composed of men and women ministers. They are licensed ministers in different Hispanic churches in the area. They are also a diverse group with marked cultural differences among the Latin American population. Some of them were originally born in Hispanic countries of South America and Central America. Others were born in the United States and thus belong to second and third generation of people whose parents or grandparents migrated to the U.S, looking for better life conditions. They do not share the same cultural roots as the foreign pastors who have established their life in Florida and gone through an enculturation process. This means that some of the participants have learned the traditional content of the general

American culture and assimilated its practices and values, while also keeping their parental traditions.

Despite their differences in terms of linguistic accents, they all speak the same language known as “Español” (Spanish). Due to some historical, political and immigration processes, Puerto Ricans represent the majority group within this population. They are followed by individuals from other nations of South American and Central America. They all share similar, but not identical traditions, customs, folklore, and food, The similar customs include Caribbean music rhythms with small but not substantial differences, worship expressions, liturgical forms, and faith manifestations, just to name a few. Even though this group of Hispanic pastors came from different Hispanic cultures, they have adopted the same Declaration of Faith of the Church of God, carrying the inheritance of the traditional roots of Pentecostalism that has spread throughout Latin-America since the last century (Dayton, 1996).

The Church of God Southeast Region is the denominational organization to which this selected group of Hispanic pastors belong. Prior to the study, the researcher obtained consent from the Church of God Southeast Region and from each participant in the study. Once the Bishop Administrator provided the required authorization, all participants were given the freedom to choose to participate in the project. The participants were able to review all the pertinent documents prior to participation in the study.

Participants

Criteria for Selection

Participants were selected using population sampling. This type of purposive sampling technique involves examining the entire population that have a particular set of

characteristics such as knowledge, experience, skills, and attributes or work (Thompson, 2012). Hispanic pastors of the Church of God in the Southeast Region, Florida, were the chosen population because they share a particular set of characteristics as ministers. They are a stigmatized population who are "not supposed" to suffer depressive symptoms due to their pastoral status. They do not have a formal established program helping them to work with this phenomenon. Most of them have little knowledge about depression or other mental disorders. They also do not know what to do when depression knocks at their doors. There is a huge need to speak out about mental health issues among the Hispanic population. Pastors, ministers, and Christians leaders are included in this need.

Description of Participants

Participants were a group of 35 males and 12 females, between the ages of 26 and 65 or older. Most of them are pastoring a church within the same denomination. The majority work in full time ministry; The others have additional full-time or part-time jobs to cover their needs. The participants have a variety of education levels. Some of them have a high level of education, while other ministers have a low level of academic achievement. However, all are or have been involved in biblical and theological education processes with the purpose of updating their required ministry knowledge.

Also, some participants are married and are fathers, mothers, or grandparents while others are single adults. A good portion of the group of participants belongs to the youth-adult minister's population.

Many of the participants are also involved in social work, education, spiritual counseling, activism, chaplaincy work, and other community service. They carry the

Church of God's credentials as ordained ministers, exhorter, or ordained bishop. All of them identified as Church of God ministers.

Ethical Considerations

The study included measures and established procedures for its implementation. Prior to the study, the researcher obtained consent from the Church of God's Bishop administrator to develop the required tests for the study and to disseminate them among the pastors. Then, when the research was ready to begin, each participant signed an informed consent appropriate for the specific pastoral position. The informed consent is found in the Appendix D.

Prior to administering the instruments, an introduction was given which showed the purpose of the study and the use of the questionnaire and test. At this stage, the potential participants were able to review the questionnaire and the BDI test and to help them understand the procedures. Participants were given information on how their responses will be used. Once they understood the importance of the study, they decided whether to participate.

I gave important emphasis to the Data Protection Act of 1998 and the guidance that it gives to researchers: "Data will be used exclusively for research purpose" (Data Protection Act, 1998). The questionnaire and the BDI test were designed for self-reported information. Thus, the confidentiality of the pastors' information is guaranteed. Participants were informed that the study was voluntary and anonymous. The demographic information was collected only for statistical purposes and not for identification.

Procedure for Collecting Evidence from Participants

The approval for this study was obtained from the Institutional Review Board (IRB) prior to the start this study.

The researcher developed an idea thought to be relevant to Hispanic pastors' mental health stability; this idea is based on current needs and concerns among the mentioned population. Once the idea was chosen, a useful question is informed. This question should be answered from the research review. The stable and measurable question asked in this study was, "What are the most common factors that contribute to experiencing major depressive disorder among Hispanic Pastors of the Church of God, Southeast Region?" The answer was sought by collecting meaningful data.

The research was grounded in the Church of God Hispanic ministry, Southeast Region, giving the researcher the opportunity to interact with the group of pastors, as the sample participants within their environment. The researcher was able to provide a pre-instruments clarification time to prepare the administration of the Questionnaire and BDI test, without unneeded information that could contaminate the data. Since experience most commonly is observed outside of libraries and laboratories, this study is taken as a field research, using both the Questionnaire and the BDI test. The intention is to make sense of the reality of Major Depressive disorder among Hispanic pastors in the Southeast Region (Dulock, 1993).

The introductory dialogue facilitated the environment that was needed to obtain data using the Questionnaire and the BDI test. The purpose was to obtain quantitative and qualitative information about participants' depression, demographics, experiences, perceptions, and general knowledge about major depression disorder. The findings are

replicable because the research used a combined method of qualitative/quantitative research. While qualitative method allows wide and nuanced interpretations, the data can only be made concrete through figures postulated by quantitative methodology that requires the use of closed questions and close-ended answers. (Richards, 2006). It means that the data analysis consists of and comes from the questionnaire responses for clarity of the problem and connection with the purpose statement and research questions. The responses from participants were organized based on the different themes to determine the frequency of each theme in the responses and ascertain how these themes were related to the research question and study. Results from Questionnaire and BDI test were used for the data analysis.

The researcher obtained consent from the office administration and from participants before administering the instruments. This protected their rights within the guidance of the Data Protection Act of 1998. The Beck Inventory Depression test provided the data needed for the study. Additionally, it gave room to develop a variety of hypotheses and provided answers for the research questions.

The selection process was simple because all Hispanic ministers with denominational credentials provided by the Church of God organization were eligible to participate. This process narrowed the eligible participants and made the general data succinct and the quantitative information more condensed.

In the process of administering the instruments, there will be potential questions that would lead the participants to obtain a substantial amount of information that is useful to a holistic understanding of the topic. It is a time-consuming process, but it is still needed.

The study involved participants from a specific region of the Church of God in a Hispanic context (Creswell, 2003). While the group of participants might be a representative sample of a pastoral community, major depressive disorder is too complex to properly encapsulate in the study of a small group of pastors. All groups and individuals have different ways of dealing with major depression disorder. The responses drawn from participants of this study can only be used on a general basis.

Questionnaires tend to be more appropriate to outline both qualitative and quantitative information since they collect standardized data. The questionnaire and BDI test employed in this study depend entirely on the personal responses of the participants themselves. The researcher took steps to ensure that the participants clearly understood the questionnaire and test and that all the responses would remain confidential and anonymous. The researcher assumed that all the participants' responses were honest to their best possible knowledge, even if they felt their personal responses might be detectable or identifiable thus limiting the risk of dishonest or non-accurate responses. Nevertheless, the possibility that participants' might not be totally truthful in their answers could not be ruled out.

Some assumptions were made in the process of the study. First, the researcher believed that the participants' biblical, theological, and secular educational experiences largely influenced their responses during the administration of the instruments. Second, the instruments used in the study were responded to honestly and effectively captured the core concepts of the research. Third, the results of this study support the future exploration of treatment alternatives such as group therapy or individual therapy where it can be applied to cognitive behavior and/or other techniques. Fourth, the study provided

significant information for Hispanic pastors, mental health professionals, and individuals considering mental health services for this population. This study also supported research by providing additional data related to this population and thereby strengthened the field of research. Finally, this study increased the knowledge and understanding amongst Hispanic pastors of major depressive disorder.

Procedure for Analyzing Evidence from Participants

Qualitative Information

The overview of the data is presented in a table format, emphasizing the underlying patterns and the most appropriate findings. The table format includes classifications presented in the form of themes, participants demographics, coping mechanisms, the measuring of Depressive behavior, and the used methods of intervention.

To highlight the underlined patterns and underscore the emphasis of the questionnaire and the Beck Inventory Test, the findings are presented in tabular form. The results are demarcated in a summary of the statistical outcomes. Both instruments and the results are included in the appendices. Occurrence tables and graphic statistics were created to present results, followed by the appropriate narrative analysis. All the analysis contains the highlight of several aspects that are related to each participant and will be part of the general analysis. The answers from all the participants were used for data analysis.

To ascertain the education level of each participant, the criteria included high school, college, bachelor's degree, or additional vocation. The participants could also state their employment status, years pastoring including their counseling experience, and

knowledge or any type of training they had received. This basic information was summarized in the tables and presented in raw data. It was then subject to a descriptive statistical analysis.

Questions provided information about the participants' personal and educational backgrounds while maintaining the methods aligned with the Data Protection Act.

Reliability and Validity of the Project Design

To achieve both validity and reliability, the questions sought to obtain only applicable and relevant information from participants. The questions focused on precise topics and sought to obtain a balanced response that allowed for a broader interpretation of qualitative data. The researcher carefully followed instructions by Creswell, which provided guidelines for setting questions for a research project.

The instruments were administered a specific group of participants guaranteeing that external validity applied only to the Hispanic pastors of the southeast region of the Church of God. Results cannot be generalized to other contexts. A survey tool online link sent to the participant via email was used to administer the instruments. This process guarantee confidentiality and did not threaten the internal validity in this study.

The questionnaire included topics related to personal and demographic information, knowledge about major depressive disorder, the participants' perception of their ability and competency to provide accurate information of their own symptoms, and their understandings of the implications of having major depressive symptoms. The instrument provided the foundation to establish what group was going to be tested. All questions were designed to consolidate the needed information for the study.

Quantitative Information

The quantitative findings were based on the frequency or occurrence level and percentages of the responses. The data analysis began by measuring responses to a questionnaire and the BDI test for uniformity and clarity. All the questions were multiple choice, and the answers were organized based on different topics. To get familiar with the data and determine the segments of information that helped form categories, the researcher read and studied the data several times (Creswell, 2003). He then calculated the frequency of occurrence and percentages and used numeric and statistical terms to determine how the topics were linked to the study and the research questions.

The researcher analyzed the data upon receiving the results that contained the demographic information that participants provided by answering the questionnaire and the test. Part of the questionnaire outlined details about participants' gender by noting whether they were male or female. The questionnaire identified the respondents' specific age group, as 18-25, 26-29, 30-39, 40-49, 50-59 or over 60 years of age. In addition, participants provided information regarding their race and nationality. Marital status was classified as single, married, separated, divorced, or widowed.

Beck Inventory Test was analyzed in a similar way. The BDI includes an analysis table indicating the highest ranking of causes of depression by the respondents. A narrative analysis allowed the researcher to describe how BDI's results were related to major depressive disorder and dysthymia in the light of the literature review.

For this study, BDI II test was used to evaluate depression in Hispanic pastors at the Church of God in the Southeast Region. The test measured cognitive, affective, somatic symptoms, neuro-vegetative and endogenous aspects of depression. The test was

used to assess only the severity of depression. One of the main objectives of the BDI II test for this study was to obtain a closer diagnostic criterion for major depressive disorder. The added items on the questionnaire complemented the BDI II and increased the content validity of the measure.

Internal consistency of the BDI II ranges from .73 to .92 with a mean of .86 (Beck, 1988). The BDI II demonstrates high internal consistency, with alpha coefficients of .86 and .81 for psychiatric and non-psychiatric population respectively (Beck, 1988). Beck did not recommend conventional test-retest reliability for his original measure for the BDI (Beck A.T., 1961). If the test is re-administrated in a short interval, results can be inflated due to memory factors. If the test is administrated after a long interval, then consistency would be lower due to the intensity of depression.

CHAPTER 4

EVIDENCE FOR THE PROJECT

Overview of the Chapter

The purpose of this chapter is to present the results of the study. This section contains the restatement of the problem, the procedure for testing, and the findings of the study.

The focus of this study concentrated on the causes and impact of major depression disorder in Hispanic pastors of the Church of God Southeast Hispanic Region and how they are dealing with depression. This chapter addresses the research questions to the light of the questionnaire and the Beck Depression Inventory test.

Participants

A group of fifty-five Hispanic ministers of the Church of God organization in the Southeast Region listened to the explanation of the study. Eight of the fifty-five ministers decided not to participate, but forty-seven consented to participate in the study. They were a group of thirty-five males (74.46%) and twelve females (25.53%), for a total of forty-seven active participants. The participants were between the ages of 26 and 60 plus years old.

The active participants were married, fathers, mothers, grandparents, or single adults. A good portion of the group of participants were the youth-adult ministers. Forty out of forty-seven active participants worked in ministry full-time job, but the others are bi-vocational pastors. The participants had a variety of education levels. Some had a high level of education, while others had a low level of academic achievement. However, all

of them are or have been involved in biblical and theological educational programs with the goal of updating the knowledge required for their ministry.

Participants were also involved in social work, education, spiritual counseling, activism, chaplain work, and other community service. They all carry Church of God's credentials as ordained ministers, exhorter, or ordained bishops. All of them identified as Church of God ministers. The demographic data is summarized as follow:

Table 4.1 Age, Gender, and Ethnic Origins

Features	Respondents	Percentage
Q1. Age of Participants		
18-25	0	0.00%
26-29	1	2.13%
30-39	4	8.51%
40-49	14	29.79%
50-59	15	31.91%
60 and older	13	27.66%
Q2. Gender		
Males	35	74.47%
Females	12	25.53%
Q3. Ethnic Origins		
Hispanic/Latino	47	100%

As shown in Table 4.1, the first four questions (Q1–Q3) contain the participant's limited personal information to determine their age, gender, and ethnic origin.

Most of the participants' age were 40 years old and up, representing the 89.36% of participants. The majority of the participants were males 74.47%, and females made up 25.53% of the group. All participants were Hispanic, and Spanish speakers. They had no difficulties comprehending questions that were presented in Spanish (Q3).

Table 4.2 Marital Status

Q4. Marital Status		
Married	45	95.74%
Single	1	2.13%
Divorced	0	0.00%
Separated	0	0.00%

Widowed	1	2.13%

Table 4.2 contains the marital status of participants. Forty five out of the forty-seven respondents reported being married meaning that 95.74% were married, compared to the 4.26% respondents who were not representing one widowed and one single participant.

Table 4.3 contains the next three questions' results (Q5-Q7) which highlighted educational and career information of the respondents. The results regarding the level of education among participants is considerably high with 80.84% holding between an associated degree to doctoral degrees (Q5). It is significant that 19.32% of the participants are limited to only a high school diploma or sporadic college experience or non-formal education. An important group of nine out of forty-seven respondents have not taken the time to be academically prepared, perhaps because ministry work is demanding and time consuming. Pastors are unlikely to take interest in counseling courses given the general perceptions of established counseling curriculums.

Table 4.3 Educational and Career Information

Q5. Educational Background		
Doctoral degree	8	17.02%
Master	12	25.53%
Bachelor's degree	11	23.40%
Associate degree	7	14.89%
Some college	5	10.64%
Vocation/Technical school	0	0.00%
High school or equivalent	3	6.38%
Grammar school	0	0.00%
Other	1	2.13%
Q6. Years of Pastoral Experience		
Less than 12 months	0	0.00%
1 to 5 years	3	6.38%
6 to 10 years	2	4.26%
11 to 15 years	6	12.77%
16 to 20 years	8	17.02%
21 years or more	28	59.57%
Q7. Are you currently pastoring?		
Yes	40	85.11%
No	7	14.89

Forty out of the forty-seven respondents reported currently pastoring, representing 85.11%, compared to the other seven participants representing 14.89% who responded that they were not pastoring any church at this moment (Q7). Twenty eight out of the forty-seven participants (59.57%) reported having 21 or more years of pastoring experience (Q6). Another 29.79% of participants reported having between 10 and 20 years of pastoring experience.

Table 4.4 Reported Participant's Location Data

Q8. Which of the following best describes the area where you live in?		
Rural	5	10.64%
Suburban	18	38.30%
Urban	24	51.06%
Q9. Which of the following best describes the area you attend church?		
Rural	5	10.64%
Suburban	17	37.16%
Urban	25	53.19%

Table 4.4 contains the last two questions of the demographic questionnaire (Q8-Q9) underlined the living area, and the location area where participants are currently assisting or pastoring. Most participants, 51.06%, live in urban areas and 53.19% are pastoring in urban areas where the population of the cities is over 90,000 habitants. Another 38.30% of participants are living in suburban where the cities have a population between 6,000 to 89,000 habitants. Most who live in the suburban area also pastor in the same area as shown in the results that 37.16% of the participants pastor in suburban areas (Q8-Q9).

These percentages show that most participants are not only engaged in ministry but also carry a good level of experience working with others in high density areas. Additionally, the results show that those pastors live the needs and experiences of belonging to a city of the same characteristics.

Research Question #1: Description of Evidence

The research addressed the four research questions. The research questions guided the study and allowed the researcher to conceptualize depression independently of the limits of clinical narratives and expectancies. The following research questions were responded and verified.

"What are the most common symptoms of major depressive disorder among leading and non-leading pastors in the Church of God Hispanic Ministry Southeast Region?"

Common Symptoms of Depression Reported

Research question one focused on the common symptoms which Church of God Hispanic pastors in the Southeast Region encountered. The following section, beginning with Table 4.5 is focused on these most common symptoms of Major Depression Disorder reported by Hispanic Pastors in the Church of God Southeast Region.

Table 4.5 Personal Experience with Depression

Q11. Have you ever experienced depression?		
Yes	30	63.83%
No	17	36.17%
Q12. How often do you feel depressed?		
Always	0	0.00%
Sometimes	12	25.53%
Not often	24	51.06%
Never	11	23.40%

Table 4.5 displays an interesting contrast showing that 63.83% of the participants reported having experienced depression, compared to the 36.17% who reported not having experienced any depression episodes or symptoms (Q11). This Q11 limited the answer to yes or no. However, Q12 opened the possibility to respond with a "sometimes 25.53%, or not often 51.06%". The results shown that 76.59% have experienced

depression in their life, compared to 23.40% reporting not having ever experienced depression in their life.

Table 4.6 Reported Responses from the Participant's Perspective Regarding Depression' Symptomatology

Q23. In your opinion, what is the most important symptom of a pastor experiencing depression?		
Symptoms	Respondents	Percentages
Feeling of hopeless, helpless and guilt	10	21.74%
Loss of interest or pleasure in hobbies/activities that were once enjoyed	10	21.74%
Feelings that you have a lot to look forward to	5	10.87%
Feeling trapped with not options	3	6.52%
Feelings that you have lost control of your life and future	2	4.35%
Feeling overwhelmed	10	21.74%
Decrease of energy and fatigue	2	4.35%
Insomnia or excessive sleep	0	0.00%
Appetite and/or weight loss or overeating and weight gain	1	2.17%
Thoughts of death and/or suicide attempts	2	4.35%
Restlessness and Irritability	0	0.00%
Persistent physical symptoms that do not respond to treatment such as headaches, digestive disorders, and chronic pain	1	2.17%
1 out of the 47 participants did not respond Q23		

Table 4.6 shows the depression symptomatology considering the participants' response to Q23. Th options presented for the participants to select Q23 are the registered symptomatology of the DSM 5 for major depression disorder diagnostic criteria (DSM-5, 2013). A total of 21.74% of the participants reported feeling of hopeless, helpless and guilt. Another 21.74% reported a loss of interest or pleasure in hobbies/activities that were once enjoyed, while another 21.74% reported that the main symptoms are feeling overwhelmed. The other significant response was the 10.87% said that it is feelings that you have a lot to look forward to. The remainder of the answers were summarized in 6.53% feeling trapped

with no options, 4.35% experiencing a decrease of energy and fatigue, and 4.35% having thoughts of death and/or suicide attempts.

The Q23 answers also provided important data reinforcing the presence of "loss of interest or pleasure" and "depressive mood" (Feeling sad, empty hopeless or overwhelmed). To diagnose major depressive disorder, five or more of the symptoms must be present and at least one of the symptoms must be loss of interest and fatigue and depressive mood. The results are significant as those symptoms were reported by Q23 with the highest percentage 21.74%.

Beck Depression Inventory II Results

Starting with the Table 4.7, the results of the Beck Depression Inventory test II are presented below. The 21-item self-administered test is scored on a scale of 0–3 in a list of four statements arranged in increasing severity about a symptom of depression. BDI-II test also assesses the presence and intensity of mood symptoms. The scale is originally divided into 2 subscales, affective symptoms (8 items) and somatic symptoms (13 items). Numerical values of zero, one, two or three were assigned to each statement to indicate the degree of severity. The results are presented, showing each question, the number of participants, and the final percentage of each response. A total of forty-seven active participants responded to each of the 21 items, without exceptions, providing a more accurate result derived from the sample.

Before seeing the results in detail, it is significant to mention that 40 out of forty-seven active participants, 85.10%, are currently pastoring a church. The Church of God, Hispanic Southeast Region reported 109 ministers that are currently pastoring a church,

and all were invited to participate in this study. The results show that 40 (36.69%) of the 109 active pastors consented to participate in the study.

The study did not intend to create an individual diagnosis for each participant. The goal was to obtain general statistics from the group of participants as a whole and not individually.

Table 4.7 BDI (Q1) Sadness

Features	Respondents	Percentage
BDI, Q1 Sadness		
1. I do not feel sad	38	80.85%
2. I feel sad much of the time	8	17.02%
3. I am sad all the time	1	2.13%
4. I am so sad and unhappy that I can't stand it	0	0.00%

Based on the descriptive statistics of the results the important findings were as as follow: Q1 While most of the participants said that they had significant feelings of sadness, 17.01% reported feeling sad most of the time and 2.13% reported feeling sad all the time.

Table 4.8 BDI (Q2) Pessimism

BDI, Q2 Pessimism		
1. I am not discouraged about my future	38	80.85%
2. I feel more discouraged about the future that I used to	9	19.15%
3. I do not expect things to work out for me	0	0.00%
4. I feel the future is hopeless and will only get worse	0	0.00%

Question 2 was about pessimism, and 19.15% reported feeling more discouraged about the future than before. Even though most of the participants do not seem to be pessimistic about the future, 9 out of 38 is a significant number.

Table 4.9 BDI (Q3) Past Failure

BDI, Q3 Past Failure			
1.	I do not feel like a failure	39	82.98%
2.	I feel I have failed more than I should have.	8	17.02%
3.	As I look back on my life, all I can see is a lot of failures.	0	0.00%
4.	I feel I am total failure as a person	0	0.00%

The same tendency occurred with Q3 where most of the respondents reported not feeling like a failure. Still, 17.02% feel they have failed more than they should have.

Table 4.10 BDI (Q4) Loss of Pleasure

BDI, Q4 Loss of Pleasure			
1.	I get as much as much pleasure as I ever did from the things I enjoy.	32	69.57%
2.	I do not enjoy thing the way I used to	10	21.74%
3.	I get very little pleasure from the things I used to enjoy	4	8.70%
4.	I cannot get any pleasure from the things I used to enjoy	0	0.00%

The tendency continued in Q4, as more than a half of respondents did not report significant difficulties. However, Q4 also showed a change in that tendency with 21.74% saying that they do not enjoy things the way they used to and 8.70% indicated very little pleasure from the things they used to enjoy.

Table 4.11 BDI (Q5) Guilty Feelings

BDI, Q5 Guilty Feelings			
1.	I do not feel particularly guilty	30	63.83%
2.	I feel guilty over many things I have done or should have done.	17	36.17%
3.	I feel quite guilty most of the time	0	0.00%
4.	I feel guilty all the time	0	0.00%

The Table 4.11 BDI Q5 displayed an increase in that tendency as 36.17%, meaning 17 out of 47 participants reported feeling guilty over many things they have done or should have done. Q4 revealed also that 1 of the 47 respondents decided to not

respond this question. What is more interesting is that Q5 answers seems to be polarized between “I feel (36.17%)”, and/or “I do not feel (63.83%)”, but no respondents appear to like the options of having experienced excessive guilty feeling or reporting it in excess over time.

Table 4.12 BDI (Q6) Punishment Feelings

BDI, Q6 Punishment Feelings			
1.	I do not feel I am being punished	42	89.36%
2.	I feel I may be punished	4	8.51%
3.	I expect to be punished	1	2.13%
4.	I feel I am being punished	0	0.00%

In response to Q6, punishment feelings seem to return to the initial pattern. Here, 89.36% reported not feeling they have been punished at all. However, 8.51% have reported feeling they may be punished, and 2.13% at least one participant expects to be punished which is cause for concern.

Table 4.13 BDI (Q7) Self-Dislike

BDI, Q7 Self-Dislike			
1.	I feel about myself as ever	39	82.98%
2.	I have lost confidence in myself	5	10.64%
3.	I am disappointed in myself	1	2.13%
4.	I dislike myself	2	4.26%

Table 4.13 is reporting the same scenario as Q7 responses where 10.64% of the respondents said they have lost confidence in themselves and 4.26% dislike themselves, indicating that some of the participants are experiencing potential depression symptomatology.

Table 4.14 BDI (Q8) Self Criticalness

BDI, Q8 Self Criticalness			
1.	I do not criticize or blame myself more than usual	36	76.60%

2.	I am more critical of myself than I used to be	6	12.77%
3.	I criticize myself for all of my faults	5	10.64%
4.	I blame myself for everything bad that happens	0	0.00%

In terms of self-criticalness and in response to Q8 12.77% reported that they are more critical of themselves than they used to be, and 10.64% said that they criticize themselves for all their faults, in contrast to the 76.60% who responded that they did not criticize or blame themselves more than usual.

Table 4.15 BDI (Q9) Suicidal Thoughts and Wishes

BDI, Q9 Suicidal Thoughts and Wishes			
1.	I do not have any thoughts of killing myself	47	97.92%
2.	I have thoughts of killing myself, but I would not carry them out	1	2.08%
3.	I would like to kill myself	0	0.00%
4.	I would kill myself if I had the chance	0	0.00%

One of the potential consequences of depression is related to the presence of suicidal thoughts or attempts to commit suicide. Q9 has to do with the phenomenon. One person endorsed this suicide item. Someone seems to be interested in this question as results are showing 48 answers, but 7 skipped responses compared to the regular 47 active participants' pattern. Most of the respondents, a total of 97.92%, indicated that they do not have any thoughts of killing themselves and the absence of suicidal attempts. However, the statistical description shown that there is a 2.08% reporting thoughts of commit suicide, but with no intention to carry them out. For this study, it is an astronomical number because this is a sample population.

Table 4.16 BDI (10) Crying

BDI, Q10 Crying			
1.	I do not cry any more than I used to	36	76.60%
2.	I cry more now than I used to	7	14.89%

3.	I cry over every little thing	1	2.13%
4.	I feel like crying, but I can't	3	6.38%

People who have depression may find themselves crying frequently for no apparent reason. A total of 76.60% that they have no more crying episodes than they used to. However, the answers still imply that everyone experience those episodes. What makes the difference for the purpose of the study is that the other 23.40% indicated irregularities in crying as a natural and normal expression of the human being. The largest number in this group ,14.89%, cry more now than they used to while 6.38% feel like crying, but they cannot. The other 2.13% cry over every little thing Q10. In other words, 11 out of 47 of the respondents are currently experiencing crying difficulties.

Table 4.17 BDI (Q11) Agitation

BDI, Q11 Agitation			
1.	I am not more restless or would up than usual	31	65.96%
2.	I feel more restless or wound up than usual	12	25.53%
3.	I am so restless or agitated, it's hard to stay still	2	4.26%
4.	I am so restless or agitated than I must keep moving or doing something	2	4.26%

The question related to experiencing agitation, Q11, gauged information regarding tension, restlessness, and/or emotional distress. A total of 34.05% of participants chose an option that reflects a severity level. 25.53% responded feeling more restless or wound up than usual, and 4.26% chose to report being so restless or agitated that it's hard to stay still. The other 4.26% experience restlessness at the level of having to keep moving or doing something. Restlessness refers to the inability to sit still or hand wringing, including pacing as one of the important symptoms of depression.

Table 4.18 BDI (Q12) Loss of Interest

BDI, Q12 Loss of Interest			
1.	I have not lost interest in other people or activities	35	72.92%
2.	I am less interested in other people or things than before	9	18.75%
3.	I have lost most of my interest in other people or things	4	8.33%
4.	It's hard to get interested in anything	0	0.00%

Q12 is shows the same variable where participants submitted their answers. One more participant seems to be interested in adding a response to this question. It seems that someone read all the questions but only one or two of the questions caught his/her attention. The same thing happened in Q9. The common denominator up to the question 11 (Except Q9) was 47 answered and 8 skipped. Q12 shown 48 answered and 7 who decided to not respond. Evidently, the topic caught the attention of someone who opted not to take the entire test. A total of 18.75% reported being less interested in other people or things than before, while 8.33% have lost most of their interest in other people or things. The result is interesting since 13 out of 48 or 27.08% of respondents are experiencing loss of interest in other people or things.

Table 4.19 BDI (Q13) Indecisiveness

BDI, Q13 Indecisiveness			
1.	I make decisions about as well as I ever	31	65.96%
2.	I find it more difficult to make decisions than usual	15	31.91%
3.	I have much greater difficulty in making decisions than I used to	0	0.00%
4.	I have trouble making any decision	1	2.13%

Pastors are constantly making both small and big decisions. Indecisiveness is one of the problems a pastor with depression experiences, even when it comes to making small decisions. BDI Q13, indicated that an overwhelming 31.91% of the respondents

find it more difficult to make decisions than usual. Indecisiveness, as one of the depression symptoms, can freeze a person to the point that he or she cannot even get out of bed for fear making wrong choices.

BDI Q14 asked about worthlessness. Table 4.20 shows the severity of the problem falls on 18.75% of the respondents, who split their responses. A total of 14.58% consider themselves as less worthwhile and useful than they used to. Another 4.17% reported feeling more worthless as compared to others. The tendency continued as, the more severe the problems is, the number of respondents decreases. The Q14 also revealed that 81.25% of participants did not report feeling worthlessness.

Table 4.20 BDI (Q14) Worthlessness

BDI, Q14 Worthlessness			
1.	I do not feel I am worthless	39	81.25%
2.	I don't consider myself as worthwhile and useful as I used to	7	14.58%
3.	I feel more worthless as compared to others	2	4.17%
4.	I feel utterly worthless	0	0.00%

The same variable of Q9, and Q12 occurred here in Q14. Only 47 of the participants responded to most questions, but someone who opted out of taking the entire test chose to answer this question.

Table 4.21 BDI (Q15) Loss of Energy

BDI, Q15 Loss of Energy			
1.	I have as much energy as ever	28	58.33%
2.	I have less energy than I used to have	17	35.42%
3.	I do not have enough energy to do very much	3	6.25%
4.	I do not have enough energy to do anything	0	0.00%

Lack of energy is commonly related to depression. Two phenomena occurred in BDI Q15. First, the additional respondent seems answered the question, and second, an

important change in the severity of the symptoms appeared. Almost half, 41.67%, reported experiencing or having loss of energy problems. Another 35.42% reported having less energy than they used to have, while 6.25% said that they do not have enough energy to do very much.

Table 4.22 BDI (Q16) Changes in Sleep Pattern

BDI, Q16 Changes in Sleep Pattern		
1. I have not experienced any change in my sleeping	28	58.33%
1a. I sleep somewhat more than usual	1	2.08%
1b. I sleep somewhat less than usual	11	22.92%
2a. I sleep a lot more than usual	1	2.08%
2b. I sleep a lot less than usual	5	10.42%
3a. I sleep most of the day	0	0.00%
3b. I wake up 1-2 hours early and cannot get back to sleep	2	4.17%

Sleep patterns are affected by depression. Q16 was designed to gauge information about how many of the participants are currently experiencing difficulties in terms of oversleeping or not sleeping. Even though 58.33% reported having no difficulties in terms of changes in sleep patterns, an evident problem appeared in the responses. Q16 revealed two important groups: those who are experiencing oversleeping patterns and those who sleep less. The first group showed 4.16% (Answers 1a, and 2a) those who are oversleeping. This is not an important percentage of the symptom affecting the sample. However, 37.51% of participants responded having difficulties sleeping less as follow: Q16 (1b), 22.92% sleeping somewhat less than usual; (2b), 10.42% sleeping a lot less than usual; and (3b), 4.17% waking up 1-2 hours early, being unable to get back to sleep. The trend is evident. The existence of sleeping problems for most pastors is experienced by not sleeping enough, compared to the minority who experience oversleeping difficulties.

Table 4.23 BDI (Q17) Irritability

BDI, Q17 Irritability		
1. I am not more irritable than usual	33	68.75%
2. I am more irritable than usual	13	27.08%
3. I am much more irritable than usual	2	4.17%
4. I am irritable all the time	0	0.00%

Irritability is also associated with depression. Q17 collected information about irritability levels among participants. A total of 27.08% of participants reported feeling more irritable than usual, while only 4.17% said are much more irritable than usual. Nobody reported irritable feelings all the time. Q17 was also answered by 48 participants. 33 of them reported not feeling more irritable than usual.

Table 4.24 BDI (Q18) Changes in Appetite

BDI, Q18 Changes in Appetite		
1. I have not experienced any change in my appetite	36	75.00%
1a. My appetite is somewhat less than usual	3	6.25%
1b. My appetite is somewhat greater than usual	4	8.33%
2a. My appetite is much less than before	3	6.25%
2b. My appetite is much greater than usual	2	4.17%
3a. I have not appetite at all	0	0.00%
3b. I crave food all the time	0	0.00%

Despite of the majority responding not having changes in appetite Q18, 25.00% of the responses reveal that there is an important change related to appetite in the context of depression. Just 6.25% reported that their appetite was somewhat less than usual, while another 6.25% affirmed their appetite is much less than before. Another 8.33% reported that their appetite is somewhat greater than usual, while 4.17% said their appetite is much greater than usual. None of the participants reported having no appetite at all or craving food all the time.

Table 4.25 BDI (Q19) Concentration Difficulty

BDI, Q19 Concentration Difficulty

1.	I can concentrate as well as ever	30	62.50%
2.	I cannot concentrate as well as usual	15	31.25%
3.	It's hard to keep my mind on anything for very long	3	6.25%
4.	I find I cannot concentrate on anything	0	0.00%

Question 19 addressed an important aspect of the study. It measured the presence of concentration difficulties among participants. Even though 62.50% reported not having difficulties focusing, an overwhelmed 31.25% expressed having difficulties focusing as well as usual. Another 6.25% reported it is hard to keep their minds on anything for very long. Eighteen of the participants reported concentration problems. The number is important considering that if a person is preoccupied by negative thoughts, suffers poor sleep, loses appetite, or experiences feelings of hopelessness as a symptom of depression, then that person's concentration is bound to be affected.

Fatigue and tiredness fuel depression. Depression can make someone feel extremely tired, even after a good night's rest. Table 4.26 reports that 60.42%, meaning 29 of the active participants are not experiencing tiredness or fatigue. However, the participant's responses show that 35.42% 17 of 47 pastors were getting tired or feeling fatigued more easily than usual.

Table 4.26 BDI (Q20) Tiredness or Fatigue

BDI, Q20 Tiredness or Fatigue			
1.	I am not more tired or fatigued than usual	29	60.42%
2.	I get more tired or fatigued more easily than usual	17	35.42%
3.	I am too tired or fatigued to do most of the things I used to do	2	4.17%
4.	I am too tired or fatigued to do most of the things I used to do	0	0.00%

Also, an important 4.17% reported being too tired or fatigued to do a lot of the things they used to do, regardless of the task or the required amount of effort. Individuals

with depression often feel very tired and do not want to take part in any activities. Therefore, the accumulated results of the two groups, a 39.59% (19 participants) is significant when measuring depression.

Table 4.27 BDI (Q21) Loss of Interest in Sex

BDI, Q21 Loss of Interest in Sex			
1.	I have not noticed any recent change in my interest in sex	30	62.50%
2.	I am less interest in sex than I used to be	15	31.25%
3.	I am much less interest in sex now	1	2.08%
4.	I have lost interest in sex completely	2	4.17%

Another symptom associated with depression is a change in sex drive. In response to BDI Q21, 37.50% of the respondents expressed reduction or loss of interest in sex. Another 31.25% reported being less interest in sex than they used to be, while 2.08% reported much less interest in sex now. Another 4.17% reported they have lost interest in sex completely.

As it was previously presented in Table 4.6 Question 23 of the questionnaire, the participant's responses revealed the most common symptoms of major depression disorder among them from their own perspective. In the questionnaire 21.74% reported feeling hopeless, helpless, and guilty; another 21.74% reported loss of interest or pleasure in hobbies/activities that they once enjoyed; and 21.74%, reported feeling overwhelmed. In question 23 of the questionnaire, 21.74% was the highest percentage. In the Table 4.28, the BDI II test results display the most important symptoms of major depression disorder among the participants. They are presented from the accumulated highest percentage down as follow:

Table 4.28 below presents the results as follows: BDI Q15 Loss of Energy, and Q16 Changes in sleep pattern have the highest percentage of most common symptoms among participants, with 41.67% respectively.

Within the scale of 30% to 40%, another group of symptoms are presented with specific characteristics. The BDI, Q20 which asked about tiredness or fatigue had 39.59% of the respondents affirm that they were experiencing tiredness. This fit perfectly within the group of physical symptoms related to depression that BDI Q15, Q16 queried (Loss of Energy and Changes in sleep pattern).

Having difficulty concentrating was the symptom that BDI Q19 queried. An important 37.50% of the participants gave positive responses. BDI Q21 asked about the loss of interest in sex with the same results, 37.50%. BDI Q5 Guilty Feelings shows a 36.17% with special importance considering the demographic question 23 where 21.74% of the participants said that in their opinion the most common depressive symptoms are feeling hopeless, helpless, and guilty.

BDI, Q13 indecisiveness 34.21%, BDI, Q11 agitation 34.05%, BDI, Q17 irritability 31.25%, and BDI, Q4 loss of pleasure 30.44% displayed the highest percentages among participants. The presence of these symptoms makes the appearance of depression highly possible among the participants. The responses to BDI Q4 are displayed on Table 4.6 Q23 responses, where participants reported loss of pleasure with a 21.74%.

Table 4.28 Reported Summary of Depression Symptoms as Presented in the Beck Depression Inventory Test II

BDI, Q16 Changes in Sleep Pattern	41.67%
BDI, Q15 Loss of Energy	41.67%
BDI, Q20 Tiredness or Fatigue	39.59%
BDI, Q19 Concentration difficulty	37.50%

BDI, Q21 Loss of Interest in Sex	37.50%
BDI, Q5 Guilty Feelings	36.17%
BDI, Q13 Indecisiveness	34.21%
BDI, Q11 Agitation	34.05%
BDI, Q17 Irritability	31.25%
BDI, Q4 Loss of Pleasure	30.44%
BDI, Q12 Loss of Interest	27.08%
BDI, Q18 Changes in Appetite	25.00%
BDI, Q8 Self Criticalness	23.41%
BDI, Q10 Crying	23.40%
BDI, Q1 Sadness	19.32%
BDI, Q2 Pessimism	19.15%
BDI, Q14 Worthlessness	18.75%
BDI, Q7 Self-Dislike	17.03%
BDI, Q3 Past Failure	17.02%
BDI, Q6 Punishment Feelings	10.64%
BDI, Q9 Suicidal Thoughts	2.08%

Within the scale of 20% to 30% there are other symptoms such as BDI, Q12 Loss of Interest 27.08%, BDI, Q18 Changes in Appetite 25.00%, BDI, Q8 Self Criticalness 23.41%, and BDI, and Q10 Crying 23.40%.

Within the scale of 10% to 20%, was reported the presence of sadness 10.32%, pessimism 19.15%, worthlessness 18.75%, self-dislike 17.03%, past failure 17.02% and less common, punishment feelings with 10.64%. These percentages do not diminish the importance of appearance of these symptoms within the process of diagnosing depression. The purpose of organizing them is to respond to the first research question regarding the most common symptoms of major depressive disorder among participants.

BDI, Q9 suicidal thoughts reported a 2.08% of appearance among participants. Even though this is the minor percentage reported among symptoms in the study, it represents a significant concern to be taken in consideration for future recommendations.

Research Question #2: Description of Evidence

What are the most common causes that contribute to the growing problem of Major Depressive Disorder among leading and non-leading pastors of the Church of God Hispanic Ministry Southeast Region?

Research question 2 explored the common perceived causes of Depression among Hispanic pastors in the Southeast region of the Church of God. The following table reports the data related to this question.

One of the central themes in this study was causes contributing to the presence of major depression disorder. Question Q22 of the questionnaire was designed as an open question, framed to explore the predominant causes of depression for those involved in ministry among Hispanic pastors of the Church of God Southeast Region. A significant 56.52% agreed that stress and burnout in ministry was the main cause of depression among these pastors.

Table 4.29 Reported Most Common Causes of Major Depression Disorder

Q22. In your opinion, what do you think are the cause(s) of depression among pastors?	
Stress and burnout in Ministry	56.52%
Family issues	19.57%
Finance	4.35%
Loneliness/Isolation	4.35%
Other	4.35%
Self-pleasure and/or sexual habits	2.17%
Demonic influence	2.17%
A rundown physical condition	2.17%
Excessive drugs/Alcohol use	0.00%
1 out of the 47 active participants did not respond Q22	

Among the other reported causes of depression among participants, Q22 identified a 19.57% related to family conflicts, finances, lack of exercise, loneliness, and isolation with 4.35% respectively. Low percentages referred to demonic causes, rundown physical conditions, and self-pleasure and/or sexual habits. The findings did not associate

the use of alcohol or drugs as a cause of depression among Hispanic pastors of the Church of God Southeast Region.

Table 4.29 shows that stress and burnout in ministry with 56.52% is the most common reported cause of depression among Hispanic pastors of the Church of God Southeast Region. This is corroborated by the participants' responses shown in Table 4.30 (Q17) where 40.43% reported that they have felt burned out within the first five years of their ministry as shown below.

Table 4.30 (Q17) Reported Burnout in Ministry

Q17. Have you felt burned out within the first five years of your ministry?		
Yes	19	40.43%
No	28	50.57%

Burnout is an extension of stress and an entry point for depression (Christie, 2013). The participants' responses clarified that pastors tend to become overly involved emotionally, overextend themselves, and overwhelmed by the emotional demands imposed by their pastoral duties and their own family issues to the point of experiencing burnout in ministry.

Taking into consideration health, social relationships, productivity, suicide, and dependency. Participants were asked what they think is the most negative effect of experiencing depression (Q25).

Table 4.31 Reported Negative Effects of Experiencing Depression

Q25. Taking in consideration health, social relationships, productivity, suicide, and dependency, what do you think is the most negative effect of experiencing depression?		
Suicide	9	19.74%
Loneliness	8	17.02%
Lack of energy and interest	4	8.51%
Since this is an open question, 26 out of the 38 responses, representing a 54.73%, responded with a variety of answers, but the answers listed above (45.27%) were the most common responses to Q25		
9 out of 47 active participants did not respond Q25		

An important 19.74% reflect an increase in awareness regarding suicide among pastors. They reported that suicide is the most negative effect of the presence of depression. Loneliness was reported by 17.02% and once again, lack of energy and interest was reported by 8.51% of the participants. Nine out of 47 active participants decided to not answer Q25. Q25 was an open question, and there were a variety of answers, 54.73%, that are not included in the above list, but the answers above (45.27%) were the most common responses to Q25.

Research Question #3: Description of Evidence

What are the most typical and popular non-formal approaches this population uses to deal with depression symptoms?

Research question 3 inquired about the most typical and popular approaches that these pastors employed in their attempts to address depression. The following tables report all the applicable data for this question.

The results from Table 4.32 indicate the participants' perspective, knowledge, and conceptualization regarding common practices when they have to deal with depression within their congregation, among known people not belonging to the church, or even with relatives or themselves. Most, 55.32% of the participants reported having referred someone to a mental health professional. However, the practice of referring parishioners who are experiencing emotional disturbance or mental health problems seems to be absent from 14 out of the 47 active participants. During the last two years, another 29.79% reported they have not referred anyone to a mental health practitioner. Another 14.89% have never referred someone. In consequence, in at least the last two years,

44.68% responded that they had not used the mental health professional services to address mental health problems in their communities.

Table 4.32 Frequency of Referring Someone for Professional Help

Q10. How often do you refer parishioners, members of your congregation, or others for mental health counseling?		
Feature	Respondents	Percentage
None in the past 2 years	14	29.79%
1-5 times in the past 2 years	15	31.91%
6-10 times in the past 2 years	4	8.51%
11-15 times in the past 2 years	2	4.26%
Over 15 times in the past 2 years	5	10.64%
Never	7	14.89%

Table 4.33 Q13 asked if the participants had received help from a mental health counselor for depression. Q14 asked about participants who have received counseling from another pastor.

Table 4.33 Have You Ever Received Mental Health Counseling for Depression?

Q13. Have you ever received Mental Health Counseling for depression?	
Yes	14.89%
No	85.11%
Q14. Have you ever received counseling from another member of the clergy?	
Yes	42.55%
No	57.45%

An overwhelming 40 out of 47 participants or 85.11% who responded to Q13 said that they had not received mental health services. However, almost half of them, 42.55% reported having received counseling from another member of the clergy. 57.45% of them have not received help from another pastor or a ministry colleague (Q14).

The Table 4.34 focuses on the participant's use of a mental health professional to deal with depression.

Table 4.34 Measuring Intentionality, Looking for Professional Help

Q20. In the past or currently, have you looked for *professional* help when experiencing depression?		
Yes	6	13.04%
No	40	86.96
1	out of the 47 active participants did not respond Q20	
Q21. If your answer to previous question was "yes", who have you visited?		

Psychologist	3	12.50%
Psychiatrist	0	0.00%
Medical doctor	5	20.83%
Mental health Counselor	4	16.67%
Other	12	50.00%
23 out of the 47 active participants did not respond Q21		

In this context, Q20 added valuable information verifying that 13.04% (6 participants) have used professional help, while 86.96% (40 Participants) remarkably would not turn to professional help when dealing with depression. The responses made evident the preferences of respondents. Participants are not using or do not believe in the use of professional help when experiencing depression.

The Table 4.34 (Q21) also shows that participants trust their emotional problems to others (50.00%) but have a noticeable preference for non-conventional services. Half of the participants reported using professional help such as medical doctor, psychologist, or mental health counselor but excluding psychiatrist with 0.00%. Considering this, most participants felt that emotional problems should be handled preferably by themselves making the bid to get professional help less acceptable, whenever they get depressed. This makes evident the strong tendency to avoid looking for the appropriate clinical professional source to deal with depression even though they were looking for help among other professionals.

Important information related to the use of medication to treat depression among participants is reported in Table 4.35. It shows that 6.38% of respondents said that they have received medication to treat their depression (Q15). The remaining 44 participants 93.62%, reported never having used medication to treat depression. What is remarkable is that the results from Q16 show an increase in the level of confidence that the respondents have in the use of prescribed medication to treat depression among Christians. Thirty-

seven out of 47 or 78.72% answered that they agree with the use of medication, in contrast with the 21.28% who did not.

Table 4.35 Perspective about Medication to Treat Depression

Q15. Have you ever been prescribed medication for depression?		
Yes	3	6.38%
No	44	93.62%
Q16. Do you think that it is appropriate for a Christian the use of medication to treat depression?		
Yes	37	78.72%
No	10	21.28%

In Table 4.29 the 56.52% or the participants reported stress and burnout as the most common cause of depression in ministry. Table 4.36 displays the most common ways they cope with the stress of pastoral duties.

Table 4.36 Reported Participant's Coping Skills

Q24. What enables you to cope best with the stress of pastoral work?		
Do nothing or just ignoring it	0	0.00%
Reading the Bible	2	4.26%
Praying	17	36.17%
Reflecting	8	17.02%
Talking to a friend	13	27.66%
Get Counseling	6	12.77%
Antidepressant and medications	1	2.13%

As anticipated from the sample, in Table 4.36, most of the participants (36.17%) responded that prayer was the best way to deal with the stress generated by ministry and pastoral duties (Q24). Another 27.66% said that it is important to talk to a friend. A 17.02% report reflecting as one of the tools to deal with stress. What is more significant is that 12.77% (6 Participants) think of seeking counseling help when they experience stress, and only 2.13% said they had turned to antidepressant/medication to deal with the stress caused by ministry.

Research Question #4: Description of Evidence

How does the severity of Major Depressive Disorder affect the life and ministry of pastors of the Church of God Hispanic Ministry Southeast Region?

The final question in this research project investigated the impact of major depression disorder on the life and ministry of the pastors of the Church of God Hispanic Ministry in the Southeast Region.

More than half of the participants reported having experienced depression Table 4.05 (Q11), 63.83%. Other data in the findings also provide clues to the presence of depression in the life of Hispanic pastors of the Church of God Southeast Region, allowing us to deduce the severity of the phenomena.

Closely associated with depression is the concept of "burnout", a term defined by the feeling of exhaustion, frustration, anger, and a sense of ineffectiveness and failure (Freudenberger, 1980). The data from Table 4.30 regarding burnout in ministry clarifies research question #4 regarding the severity of depression, even though it was part of the data used to clarify research question #2 regarding the causes of depression.

Pastors are especially prone to experience burnout in ministry before depression because of the pastoral duties, and because in many ways they fail to heed the advice they give to others while they are dealing with their own depression symptoms problems (Grosch & Olsen, 2000).

Table 4.37 has data regarding burnout in ministry, and how participants typically carry the consequences of the phenomena when experiencing depression. In addition, this section also measures the personal experience in the context of the ministry.

Q17 revealed that 40.43% or 19 out of 47 of the participants have felt burned out in the first five years of their ministry. That number is significantly high. On the other

hand, Q18 revealed that 14 out of 47, or 29.79% decided to take a leave of absence from ministry because they felt overwhelmed with their congregations. This data leads to the conclusion that the severity of depression symptoms has been underestimated. Table 4.37 also reveals that a significant 70.21% of participants reported not taking any leave of absence at all.

Table 4.37 Depression and Functionality During Pastoral Duties

Q17. Have you felt burned out within the first five years of your ministry?		
Yes	19	40.43%
No	28	50.57%
Q18. Have you needed to take a leave of absence from your ministry because you felt overwhelmed with your congregation?		
Yes	14	29.79%
No	33	70.21
Q19. Have you continued pastoral duties even knowing you are experiencing depression?		
Yes	22	50.00%
No	22	50.00%
3 out of the 47 active participants did not respond Q19		

Considering the answers to Q19, if any of the participants have continuing pastoral duties even knowing they are experiencing depression, it is noticeable that 50% of them responded “yes”, and the other 50% responded “no”. Considering that in response to Q 18, 29.79% reported not having taken any leave of absence previously, 20.21% of them knew they were experiencing depression episodes but preferred not to take the leave of absence and chose to continue with their pastoral duties. Significant is also the fact that 3 out of the 47 active participants decided to not respond to Q19.

Table 4.38 shows how the severity of depression impacts the life of the respondents. The responses to Q25 are also included in this table, because both Q25 and Q26 measure how the severity of depression impacts a Hispanic pastor.

Among other answers collected by the questionnaire, Table 4.38 (Q25) shows that in the opinion of 19.74% of the participants suicide can be the most negative effect of

depression. Loneliness was also reported by 17.02%, followed by the lack of energy and interest reported by 8.51% of the participants.

Table 4.38 Reported Depression's Impact

Q25. Taking in consideration health, social relationships, productivity, suicide, and dependency, what do you think is the most negative effect of experiencing depression?		
Suicide	9	19.74%
Loneliness	8	17.02%
Lack of Energy and Interest	4	8.51%
Since this is an open question, 26 out of the 38 responses, representing 54.73%, corresponded to a variety of answers. The answers above (45.27%) were the most common responses to Q25		
9 out of 47 active participants did not respond Q25		
Q26. How do you think depression can impact the life of a Hispanic pastor?		
Isolation	7	17.94%
Family conflicts	6	15.38%
Spiritual and ministry problems	6	15.38%
Irrational thoughts	2	5.12%
Since this is an open question, 26 out of the 39 responses, representing 46.20%, corresponded to a variety of answers. The answers above (53.82%) were the most common responses to Q26		
8 out of 47 active participants did not respond Q26		

Table 4.38 (Q26) provided information about the effects and severity of depression in Hispanic pastors of the Church of God Southeast Region. The most common responses (53.82%) reported by the participants included isolation 17.94%, family conflict 15.38%, spiritual and ministry problems 15.38%, and irrational thoughts 5.12%. Other significant responses were feeling overwhelmed, irritability, imbalance in ministerial performance and the personal life, loss of strength, and hopelessness and apathy.

The findings captured reveal how participants gauge themes regarding depressive symptoms and their opinions about the most common strategies used when experiencing depression. The themes included "Perspective toward depression," "Causes of Depression," "How depression impacts the life of a pastor," "Recognition of need for help," and "Confidence in Mental Health Professionals."

The results show that depression is a reality among pastors as many of them reported having experienced the symptoms. The results also show a tendency to turn to prayers, friends, congregations and/or family members as a way of coping with depression but not confidence in mental health professionals. Participants also perceive many of the symptoms of depression such as lack of energy, loneliness, and their inability to cope with depression as causes of depression but not as symptoms.

Factors that affect the perception of participants include their professional, academic, and social backgrounds and the inclination to think as a pastor. In fact, eight out of the initial fifty-five who opened the survey link, decided to decline their participation showing some skeptical perception about dealing with or exploring the problem. Many of the questions were also declined due to unknown reasons.

Summary of Major Findings

The production of the tables and the analysis of the research questions combined with the literature review and clinical considerations led to four major findings for this project. The findings listed below are not summarized in an order of importance because all have same value for the study.

First finding: *Common symptoms of depression reported among Hispanic pastors,*

Second finding: *Commons causes of depression reported among Hispanic pastors,*

Third finding: *Approaches to dealing with depression, and*

Fourth finding: *The impact of major depression on Life and Ministry*

CHAPTER 5

LEARNING REPORT FOR THE PROJECT

Overview of the Chapter

Several challenges face pastors today. Major depression disorder is a growing concern among pastors and other religious leaders. The purpose of this study was to identify factors that contribute to the presence of major depressive disorder in Hispanic Pastors of the Church of God in Southeast Region (Florida) and its impact on their ministries to make future recommendations to address this problem. The study also assessed the factors influencing the perception of depression in pastors in relation to their demographic information, and the pastoral lifestyle. It also examined; the symptomatology experienced by these pastors using the Beck Depression Inventory II test. Additionally, it reported methods pastors use when coping with depression. This final chapter discusses the findings, ministry implications, limitations of the study, unexpected observations, and recommendations.

Major Findings

Common Symptoms of Depression Reported Among Hispanic Pastors

It was possible to identify Major Depression symptoms among participants beyond spirituality, ministry, personal, and professional experiences. Almost 64% of the 47 active participants reported having experienced the symptoms associated with major depression disorder.

Even though most pastors experienced depression symptoms, there was some resistance to exploring this possibility. Even prior to the administration of the questionnaire and the BDI II test, resistance to participate in the process was perceived.

The procedure to assist a pastor to explore possible symptoms of depression required them to explore the causes of depression, including how their lifestyles contribute to depression. For this reason, the process of examination was difficult because of the high level of confidentiality required to access their lifestyles and explore the presence of depression symptoms. Refusal to participate and acknowledge the existence of a problem was an obstacle, even among active participants. Pastors do not easily admit they are experiencing or have experienced depression symptoms because they do not want to disclose their struggles to anyone. This reluctance is also due to their inability to evaluate whether they or their colleagues suffer from depression (Lovejoy, 2014

Despite initial resistance, most of the active participants completed the questionnaire and BDI II test. The findings do agree that some of the pastors are willing to admit depression symptoms, based on two factors: their knowledge and understanding of the causes of depression gained through their pastoral experience, and the unexpected opportunity to explore their depression symptoms through this study.

During the administration of the questionnaire and the BDI II test, 63.83% of the participants had experienced depression. It was also found that the key symptoms associated with a Hispanic pastor experiencing depression are derived from their lifestyle and pastoral duties. This was reflected in feelings of exhaustion, frustration, irritation, and a sense of ineffectiveness and failure. Pastors also reported loneliness as one of the most important depression symptoms connected to ministry. The findings show that pastors displayed difficulties identifying and recognizing depression symptoms with accuracy. The description of the symptoms, as used in the BDI test, was helpful in identifying the more common symptoms of depression. The BDI test also educated the

participants about clinical symptoms of depression and revealed which of them they shared.

To be considered major depressive disorder, the clinical criteria requires that at least five of the symptoms listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) must be present and should denote a change for the individual experiencing those symptoms, producing significant distress or detriment in the social interaction and other areas (APA, p160).

Among the most significant findings, the study reported that 63.83% of the participants have experienced depression symptoms. As described previously, 14 out of the 21 BDI items reported percentages above 20% among participants. According to the DSM-5, to be considered major depression disorder, not only must five (or more) of those symptoms be present, but also at least one of the symptoms be either (1) depressed mood or (2) loss of interest or pleasure (APA, p160). Participants reported the depressed mood, associated with feeling sad, empty, or hopeless as represented in the findings as guilty feelings 36.17%, crying 23.40%, sadness 19.32%, pessimism 19.15%, worthlessness 18.75%, and punishment feelings 10.64%. Another significant statistic is that 27.08% reported the loss of interest, and 30.44% reported the loss of pleasure. The existence of depressive symptoms is evident in the findings of the study.

Observing the sample as a whole without obtaining individual diagnoses for the participants, the following Table 5.1 reflects an interesting result considering the symptomatology of the group as a whole.

Table 5.1 Reported Depressive Symptoms of the Group of Participants from the Beck II Test

	Yes	Not

Reported depression' symptoms	#	%	#	%
1. Feeling sad	9	19.15%	38	80.85%
2. Pessimism	9	19.15%	38	80.85%
3. Past failure	8	17.02%	39	82.98%
4. Loss of Pleasure	14	30.44%	32	69.57%
5. Guilty Feelings	17	36.17%	30	63.83%
6. Punishment Feelings	5	10.64%	42	89.36%
7. Self-Dislike	8	17.03%	39	82.98%
8. Self-Criticalness	11	23.41%	36	76.60%
9. Suicidal Thoughts and Wishes	1	2.08%	47	97.92%
10. Crying	11	23.41%	36	76.60%
11. Agitation	16	34.05%	31	65.96%
12. Loss of Interest	13	27.08%	35	72.92%
13. Indecisiveness	16	34.05%	31	65.96%
14. Worthlessness	9	18.75%	39	81.25%
15. Loss of Energy	20	41.67%	28	58.33%
16. Changes in Sleep Patterns	20	41.67%	28	58.33%
17. Irritability	15	31.25%	33	68.75%
18. Changes in Appetite	12	25.00%	36	75.00%
19. Concentration Difficulties	19	37.50%	30	62.50%
20. Tiredness or Fatigue	19	39.59%	29	60.42%
21. Loss of Interest in Sex	18	37.50%	30	62.50%

Summarizing the content of Table 5.1, the sample experienced the presence of depressive symptoms. Twenty out of 48 participants reported loss of energy and changes in sleep patterns which are common symptoms in major depressive disorder. Also, 19 out of the total of 49 participants experienced concentration difficulties, tiredness, and fatigue. These are also common symptoms resulting in occupational, social, and educational problems. Seventeen pastors out of 47 reported guilty feelings, which is also part of the depressed mood associated with major depressive disorder. Another 15 out of 48 participants expressed irritability, followed by the other reported symptoms, all of them with significant percentages. Those reported symptoms are supported by the DSM-5 Criteria and indicate the presence of depressive symptoms in the sample according to DSM-5 criteria (APA, p 160-171).

Chapter two of this study provided biblical and theological literature supporting what Scripture says about depression symptoms. The chapter also discussed the

psychological research about depression and its symptomatology. Both biblical and psychological research give support to the findings in terms of depression symptoms.

According to the discussion in chapter two, depression has been a real problem throughout history, even from biblical times (Cooper, 2006). The Scriptures support the presence of depression symptoms among those involved in pastoral duties. The Scriptures have numerous examples of people who experienced the symptoms of this scourge, affecting their relationship with God, others, and themselves. In the Scriptures people admitted that they were struggling with depression symptoms despite not knowing about them. For example, in Jonah 4:3 after Jonah saw God forgive Nineveh, it displeased Jonah exceedingly and he asked the Lord to take away his life, considering that dying was better than living. The Psalmist describes his countenance reflected in his words in Psalm 42, experiencing sadness, losing his appetite, crying (42:3), pouring out his soul (42:4), and feeling emotionally exhausted. He also felt overwhelmed by the waves (42:7). The Psalmist felt abandoned, rejected by God, and confused by it (42:9; 43:2). Ultimately, the symptoms of depression become evident through his writing.

In 2008, Gilley provided additional examples of physical and emotional symptoms of depression as highlighted in the Scripture, such as pessimism (Psalm 32:3), apathy and fatigue (Psalm 32:4), hopelessness (Psalm 38:2-4, 10), physical problems, such as backaches, headaches (Psalm 38:5-8), withdrawal of often blaming others (Psalm 38:11;55:6-8), feelings and knowledge of guilt (Psalm 51:3), sleeplessness or restless sleep (Psalm 42:2-3), loss of productivity (1 Kings 19:3-5), and thoughts of death or suicide (1 Kings 19:4) (Gilley, 2008).

All of this biblical correlation supports the presence of depressive symptoms among those involved in ministry. The biblical foundations about depression also reinforce the lens of scientific views of the symptomatology of depression among Hispanic pastors, which is the focus of this study.

Archibald Hart, Senior professor of Psychology at Fuller Seminary's School of Psychology concluded that depressive symptoms in a population of pastors may include changes in sleep patterns and loss of energy. Despite their investiture as pastors, they may experience depressive symptoms such as tiredness or fatigue, concentration difficulties, and loss of interest in sex. They may have guilty feelings, indecisiveness, agitation, irritability, and loss of pleasure or interest. Depressed pastors can also experience a change in appetite, self-criticalness, sadness, and crying episodes associated with depression. They can experience pessimism, worthlessness, self-dislike, and feelings of past failure, including the unthinkable of punishment feelings and suicidal thoughts (Hart, 2015).

Pastors and Christians must learn that they are not immune to experience depression symptoms, according to Hart (Hart, 2015). Depressed pastors present themselves with varying physical and mental issues that work together to bring about the depressed disorder (Dowd, 2004). Hispanic pastors are a sizable occupational group and are susceptible to depression symptoms that increase in intensity because of their pastoral duties, environment, and ministry. Andrew Knott's article provides a list of depression' symptoms in ministers: Feelings of failure, isolation, stress, frustration, feeling of punishments, anger, and unresolved inner issues (Knott, 2014). These symptoms are associated with the described clinical depressive symptoms of the DSM-5.

Common Causes of Depression Reported Among Hispanic Pastors

Beyond the consequences from their faith, spirituality, and ministry, pastors were able to identify the causes of depression. Additionally, they were able to connect the most common causes of depression with their personal and professional lives as factors contributing to the presence of major depressive disorder.

Hispanic pastors of the Church of God Southeast Region can find themselves engaged so much in the lives of others that their own emotional needs are not satisfactorily addressed. As the participants' responses demonstrated, 56.52% were experiencing stress and burnout in ministry, 19.57% were dealing with family issues, 4.35% had financial difficulties, 4.35% faced loneliness and isolation, and other causes of depression were evident. Andrew Knott also highlights some of the major causes of depression among pastors that appears to fit the discoveries in this study. He noted the role of financial struggles in relation to depression among pastors. He also noted other factors such as loneliness, social expectations, fear of failure, mental and physical fatigue, unresolved inner issues, and frustration attached to their own work, especially when experiencing spiritual warfare (Knott, 2014). Additionally, pastors have some degree of vulnerability to internal conflicts and failure to resolve difficulties either through suppression or avoidance, intensifying the possibility to experience depression in pastors (Knott, 2014).

One of the main causes of depression as presented by the findings is that participants reported having experienced stress and burnout in ministry. Table 4.29, Q22 displayed that the majority (26 out of 47) of active participants have experienced stress and burnout in ministry. Table 4.30, Q17 also shows that 40.43% reported having

experienced burnout in the first five years of their ministry. This finding demonstrated that pastors need to understand that burnout, which sometimes leads to depression is not an indication of personal failure but is triggered by the hectic and demanding work environment which ultimately can lead to experiencing depression. Bryant et al., in their article "Barriers to the Recognition and Treatment of Depression*",* recognized that religion's tendencies such as traditions, roles, and duties increases the possibilities of experiencing depression (Bryant, 2013).

To understand why Hispanic pastors of the Church of God are susceptible to depression, one must consider the kind of work in which the pastors are engaged. The participants' pastoral duties include pre-marital counseling; resolving conflicts among their congregation's families; handling grief, funeral arrangements, bereavement and loss; performing weddings and christening ceremonies; and counseling members of their congregations. Those daily routines affect their perception as they intensely engage with many issues in the lives of others. This often means that their own needs are not adequately addressed.

Pastors who are too absorbed in the ministry and pastoral duties are likely to suffer bouts of depression. Pastors are positioned to respond to almost all the emotional needs of their congregations, turning their responsibilities into a mental overload and risking their emotional health and spiritual stability. Pastors are more open to experience the scrutiny and criticism of the community, who may have unrealistic and presumptive expectations for their pastors and make unreasonable comparisons (Givens, 2014).

Pastors are also faced with problems within their families and personal lives (Payne, 2009). In this study, family issues were an important cause of depression among

the participants with a 19.57% or 9 out of 47 participants indicating the family issues were a cause of depression. Hispanic pastors face the common family difficulties that ordinary people face. An article entitled "Using Effort-Reward Imbalance Theory to Understand High Rates of Depression and Anxiety among Clergy" says, "The life of pastors is so intertwined in their church that their own life depends on the well-being of their clergy. As a result, when the pastor did not have resources to address their personal difficulties within their pastoral organization, then they exhibited disappointment, dissatisfaction and fell into depression" (Proeschold-Bell, J. P., et al. 2013).

The Scriptures also provide solid examples of people who faced stress and burnout, family issues, isolation, and the other causes of depression as reported by participants. In 1 Kings 19, Elijah is highly stressed Elijah just after he called down fire from heaven to prove the veracity of God. Then, he put to death hundreds of false prophets. Soon after, he panics and flees to the wilderness after being intimidated by Jezebel. Desire to escape, emotional distance, and a false sense of failure were all part of the causes that lead him to experience depression.

Moses was a servant-leader who worked to free the Israelites from Egyptian slavery. Imagine the level of frustration, and disappointment when the Israelites disobeyed him, or when the Egyptians cursed and teased him. Still, he accomplished the great mission for God, despite the stress and struggles that he experienced. The Psalmist admits struggling with different scenarios (Psalm 42-43), such as loneliness, feeling burned out, and unable to find the right way to the presence of God. In 2 Samuel 12, the causes of depression were evident as David experienced family issues, including losing

his son, as punishment from God for David's adultery and the murder of Uriah. These events caused David to struggle with the consequences of his sin.

The findings and the connections made in the literature supports the finding #2 as the causes of depression reported among participants. Overall, this finding demonstrates how important it is for Hispanic Pastors of the Church of God Southeast Region to look for alternative methods to prevent the struggles related to the ministry. In this way they reduce daily problems like those described above and keep the challenges from affecting their well-being and their capacity and ability to serve their communities effectively.

Approaches to Dealing with Depression

Participants in the study demonstrated conservative tendencies regarding depressive disorder and how to handle it. Some pastors showed some understanding of depression's causes and the factors contributing to the presence of depression in their lives, but they tended to use sources other than psychological ones to address the problem. For example, most pastors primarily turned to spiritual and other informal sources such as faith, another pastor, or a friend or family member to deal with depression rather than seeking psychological counseling and other proven ways to address the problem. Very few participants admitted to receiving counseling or professional help. For example, although almost 64% of the participants had experienced depression, 85.11% have not received help at all, according to Table 4.33, Q13. Additionally, Table 4.33, Q14 reported that 57.45% did not explore the option of speaking to another pastor or minister about depression. Supporting finding number three, the study also demonstrated that participants have not looked for professional help either in the past or the present when experiencing depression. Almost 86.96%, as

recorded in Table 4.34, failed to seek professional help. Furthermore, none of them sought help from a psychiatrist, and only 12.50% would get help from a psychologist, 16.67% from a mental health counselor, and only five participants would request help from the medical doctor. The other 50.00% reported having taken other unknown options to deal with depression, which probably refers to a friend or colleague.

In Table 4.35, 93.62% of the active participants disliked the use of medication to treat depression. They prefer getting help from another pastor or a friend as reflected in Table 4.33, where 42.55% of the responses supported this option.

The finding also made it clear that pastors do not like to refer church members to a professional when it comes to dealing with depression. Most participants reported not having used medication for depression most of them reported experiencing depression and having continued pastoring even though they knew they were experiencing depression.

As Table 4.34 shows the responses that participants gave when they were asked if they would look for professional help when they experienced depression or seek other options. Fifty percent indicated they would seek help from a friend, family member, another pastor, or some other kind of spiritual nourishment or counseling. The negative attitude toward seeking professional help may derive from their beliefs that such approaches contradict their biblical beliefs and their pastoral ethics. In 2013, Bryant et al. recognized that spiritual or religious inclinations can considerably contribute to a failure to admit depression. They also indicated that these same inclinations predispose pastors against using professional resources to treat depression. In the study “Barriers to the Recognition and Treatment of Depression,” Bryant et al. discussed the role spirituality

plays in terms of causes, symptoms, and treatment of depression among the persons of faith. The authors noted that there is a stigma surrounding depressive disorder which makes it difficult for people to openly discuss the issue. Pastors seem to value privacy and do want everything to be known about them. This aspect ruins any intervention methods or clinical approaches (Bryant, et al. 2013).

Pastors have a strong tendency to opt for spiritual counseling from friends or pastoral counseling as the most current and popular methods for dealing with depression. Table 4.33 reported that 42.55% have received counseling from another member of the clergy.

Once Hispanic pastors were willing to explore depression, they were also more open to discuss alternatives of professional help, but preferably those associated to their principles of faith, or their church organization. This was evidenced by the fact that despite the initial resistance to participate in the study, pastors were able to explore other options to deal with depression.

Although pastors avoided professional approaches and preferred spiritual and related methods, this does not mean that this area is not important in addressing depression. Spiritual nourishment plays an essential role in dealing with depression among Hispanic pastors. Table 4.36, reveals that pastors cope best with the stress of pastoral duties by praying (36.17%), talking to a friend (27.66%), and reflecting (17.02%). This tendency to use the spiritual nourishment is indispensable as they use it on a regular basis and consider it as an essential part of their faith. That is why it is a therapeutic tool when it comes to treating the depression of pastors. Tim Span believes that the Scripture can be used ethically and beneficially as a resource for counseling

ministers suffering depression. People engaged in ministry are more comfortable seeking help with the Bible as their primary text. He refers to 2 Timothy 2:14-15 because of its reliability and usefulness. Still, the Bible should be used responsibly (Span, 2009).

Because Hispanic pastors depend heavily on spiritual nourishment and they have a strong level of commitment to the ministry and the church organization, they feel that the religious organization is crucial to countering the symptoms of depression among Hispanic pastors. These symptoms include stress and burnout from ministry, loneliness, and family issues. Thus, the pastors are more inclined to see a spiritual counselor rather than a mental health practitioner because of their perception that depression is a spiritual crisis rather than a mental health crisis.

Another important observation is that since depression is the foremost occupational hazard for people working within the ministry, Hispanic Pastors of the Church of God Southeast region desperately need clinical intervention combined with spiritual nourishment as the way to deal with major depression disorder. The Scripture must become part of the current therapies. The Scriptures can be used to address cognitive distortions such as magnification, perfectionism, discounting the positive, and mind reading (Span, 2009). From this finding, spiritual nourishment should not be at the outlying edges of clinical intervention, but it should be central. Almost 43% of participants reported having used another member of the pastoral team as a counselor and almost 37% reported using prayer as the best way to cope with stress. Hispanic pastors of the Church of God Southeast Region need an environment where the therapist is inclined towards the Christian faith. They are likely to open up because they are in a safe environment, which is essential for a therapeutic process (Span, 2009).

These observations are supported by Biblical fundamentals. When using the Bible for therapeutic purposes, numerous events can be found that show how God is already at work in the life of the person experiencing depression. Those events include seeking Christ as highlighted in Romans 5:1-11; re-programming thinking in James 1; and reaching out to others in Philippians 1, just to name a few sections of the Bible

The Impact of Major Depression on Life and Ministry

The finding revealed clear, predictable, and potentially chronic hazards that accompany depression in the life of the Hispanic pastors of the Church of God Southeast Region. The severity of the impact of depression affected the psychical, emotional, and spiritual equilibrium of this population. The data suggested that depression represents a crisis that is both spiritual and personal for pastors who are experiencing it. This conclusion derives from the analysis of the questionnaire and the Beck Depression Inventory Test II. The participants provided enough data to measure the impact of depression among respondents.

From the presentation of the data in Table 4.37, it was observed that 40.43% of participants reported burnout in the ministry, while 29.79% reported the need to take a leave of absence from ministry because they felt overwhelmed with pastoral duties. Table 4.37 also reported that 50.00% of respondents continued pastoral duties even though they knew that they were experiencing depression. Moreover, in Q26, participants were asked how they think depression can impact the life of a Hispanic pastor. In reply, 53.82% responded it would lead to isolation (17.94%), family conflicts (15.38%), spiritual and ministry problems (15.38%), and irrational thoughts in (5.12%). Another 46.20% of participants provided a variety of other consequences derived from depression.

Taking into consideration health, social relationships, productivity, suicide, and dependency, participants were asked what they think is the most negative effect of experiencing depression (Q25). The most common responses to Q25, answered by 45.27% of participants agreed that suicide (19.74%) would be the most negative effect, followed by loneliness (17.02%,) and lack of energy and interest (8.51%) as reported. The question was answered by only 38 out of 47 active participants, showing that 19.14% of participants did not answer the question, perhaps because they do not know, or they do not want to know.

Although this study did not focus on suicide rates and the low percentage reported by participants in the BDI II Test, Table 4.15, BDI Q9 (2.08%), revealed that one of the participants had thoughts of killing him/herself, but would not carry them out. For this researcher, this number is astronomical based on the statement because the expectation is that no pastor should experience suicidal tendencies. Still, suicide is not a significant concern among the group of participants. However, Hispanic pastors know the potential consequence of what experiencing depression symptoms can bring to the life of a minister. There have been recent reports of pastors committing suicide around the world. Most of those pastors were suffering depression and even being treated for depression.

The findings reveal other aspects related to the severity of impact of depression among Hispanic pastors. The literature review gave insights into the most common consequences of depression reported by participants including isolation, family conflicts, spiritual and ministry problems, and irrational thoughts and can impact the life of a Hispanic pastor.

Isolation or feelings of loneliness are part of the role of pastors. Pastors are unprepared for it when they start pastoring a church (Wells, 2009). Other religious

organizations reported that pastors who resigned their positions within the first five years did it mainly because they felt lonely and unappreciated. Most of them stated that the number one issue precipitating their resignation was that they were not equipped for the loneliness found in the ministry. Another study found that 43% of pastors reported had only one friend (Irvine, 1997). A study by Weaver et al. (2002) in “Mental Health issues among Clergy and Other Religious Professionals: A Review of Research" reported that 16% of clergy showed signs of serious distress because of loneliness or isolation. The pervasiveness of loneliness in ministry is necessary and yet deficient during times of depression and post-depression.

Research also supports the presence of family conflicts as a consequence of experiencing depression. In a journal article published in *Review of Religious Research* (Blanton & Morris, 1999), six denominations including the Church of God (Cleveland-Tennessee) were engaged in a study of emotional well-being in pastors and their spouses. The major family difficulties after a minister experienced a depression episode caused by a crisis, were the lack of support, loneliness, work related stressors, and financial support in pastoral families (Roberts, 2004).

Research also reports high levels of stress and burnout among minister’s wives. Their levels tend to be as high as those experienced by pastors themselves (Croucher, 2003). As a consequence of pastors experiencing depression symptoms, their wives become depressed and harvest thoughts of “bringing everything to an end.” This may bring divorce. Other family members often act untouched and put on masks to hide their feelings, while others simply experience anger and frustration (Gauger & Christie, 2013).

Sarah Jane Wessels (2012) writes about how pastors' family members experience issues while struggling with their relative who is depressed. As a direct result of a pastor experiencing depression symptoms, the pastors' relatives experience suppression of their own identity, lack of privacy, feeling neglected by their spouse/parent, repressed social life, double standards prevalent in the pastor's life, lack of adequate finance, feelings of frustration, and stress and poor health. Other issues are the lack of pastoral care for the pastoral family, unfavorable congregational criticism originating from misconceptions about the pastoral family, no time for leisure, and the subsequent sexual problems deriving from the pastoral lifestyle (Wessels, 2004).

Pastors experiencing depression and its consequences in their ministry and spiritual life have been studied in numerous studies and dissertations. According to the Schaeffer Institute, the ministry is perhaps the single most stressful and frustrating working profession, more than legal, medical or political careers. They found that 70% of pastors are so stressed out and burned out that they regularly consider leaving the ministry (Krejcir, 2016). According to the statistics presented by Krejcir, 89% of the pastors surveyed have considered leaving the ministry, 57% reported they would leave if they had a better place to go, 77% felt they did not have a good marriage and 38% were divorced or currently in process of divorcing. Another 71% stated they were burned out, and they battle depression beyond fatigue on a weekly and even a daily basis. Only 23% said they felt happy and content on a regular basis (Gauger & Christie, 2013).

In addition to the depression stressors discussed in this study, being in the ministry and being a person experiencing depression like others represents a challenge. Hispanic pastors of the Church of God Southeast Region are looked upon as persons who

deliver comfort and guidance for the spiritual life of their church members. Yet, Hispanic pastors suffer from the same weaknesses and difficulties in life as their church members. Their churches assume that despite the pastors' struggles, they should be able to rise above the consequences of depression caused by several aspects of life in ministry.

The other negative consequence that participants reported was the presence of irrational thoughts when experiencing depression. The calling of God, training from Bible seminary, and in-depth Bible knowledge are not barriers to the experience of depression. Unfortunately, the majority of pastors were not prepared for the emotional challenges that are present in ministry. Furthermore, many pastors have an aversion to psychology because they have been taught and really believe that it has a humanist and not a Biblical foundation. This type of posture invalidates the opportunity to pick other disciplines that are acceptable to the ways that God supplies needs.

Although this finding implies that some participants struggle with depression to a devastating point that prevents them from functioning normally, the opposite is also true. Some ministers function quite well in the midst of the demands of pastoral duties most of the time, even during times of moderate stress and depression (Gauger & Christie, 2013). Some ministers seem to have self-adapted to live their lives in the midst of stress and depression. However, many of them have moments when they can no longer function as pastors, and even find themselves challenged as individuals.

Identifying response mechanisms is the key to deal with depression consequences. Since depression is associated mostly with emotional distress such as worrying, low self esteem, irritability, isolation, and others and causes struggles in the way the individuals think and process the responses to deal with the problem, many of those individual

common responses are not helpful but make the depression even worse (Gauger & Christie, 2013). A pastor suffering with depression wrestles with the reality of what is versus what should be worrying his soul. When pastors become depressed, many feel it is a violation of what they believe. They preach specific sermons to prevent or help with depression, yet succumb to depression themselves, feeling unable to follow what they preach and have studied in the scripture.

Pastors, like everyone else, struggle with the psyche, having distorted thoughts about reality and confusing who they are with who they are as God sees them and wants them to be. In ministry, when pastors experience depression, those distorted thoughts come to the forefront. The results are presented in the form of irrational beliefs aligned with rigid and powerful demands expressed in words such as "must," "should," "ought to," "have to," and "got to," guaranteeing a failure to live up to expectations. Albert Ellis, founder of rational emotive behavioral therapy, considers that unrealistic and irrational beliefs cause many emotional problems and self-defeating habits that lead to depression or make depression worse (Ingram, Miranda, & Segal, 1998).

Gauger presents a list of irrational thinking with which many ministers struggle when experiencing depression. The list is not exhaustive:

1. In order to be successful, I have to have a larger church.
2. I must be at every meeting, because the people need me there.
3. The people deserve the best in me at all times.
4. My family should be a model family for the church.
5. If I am not on top of my "game" at all times, the church will replace me.
6. People should follow me and listen to me because I was sent by God.

7. God should bless my church.
8. Unless my sermons are top notch, people will stop attending the church.
9. The success of the church rests on my shoulders.
10. I must be better than my peers (Gauger, 2011)

Ministry Implications of the Findings

The central theme in this study is the Hispanic pastoral community of the Church of God Southeast Region. The researcher was able to survey participants to explore their perception of the factors that contribute to the presence of major depression disorder among pastors and its impact in their lives and ministries. Hispanic pastors of the Church of God Southeast Region should consider some of the ideas and recommendations presented in this dissertation while also developing a better understanding of the problem from the clinical and pastoral perspective.

The main ministry implication of the findings is to realize the urgency and the need to establish competent methods of intervention designed especially for this Hispanic pastoral community. Possible intervention mechanisms should include clinical approaches combined with spiritual nourishment designed to prevent occurrences of the negative consequences of experiencing depression. The goal of this study is to raise awareness of the need to establish an appropriate program connected with the pastoral care ministry of the Church of God Southeast Region Hispanic Ministry with a network of clinical practitioners who do not conflict with the teachings of the church and whose expectations do not violate the principles of the medical ethics.

The findings present a challenge for mental health professionals and the organizational leadership. In addition to the implementation of ethical and legal

protocols, the organizational leaders must recognize that dealing with pastors requires considering the pastors' special needs that are not limited only to the role of being a pastor but also include acquiring the cultural competency that enables them to offer appropriate treatment for those who approach them. The benefit of using this study's suggestions is that it will help equip Hispanic pastors of the Church of God Southeast Region with resources that consider both the Scripture and clinical requirements and enable the pastor to know how to cope with depression.

The use of the questionnaire and the Beck Depression Inventory test II to collect data was designed to implement individual diagnoses in the future. Both instruments are appropriate to be used for self-report data; to evaluate the degree of pastoral care that needs to be implemented in individual cases; and to identify the areas where Hispanic pastors are most likely to need care.

Limitations of the Study

The study was based on self-report data from participants' perspectives that may be affected by recall bias, self-selection of the study, and the pastor's possible desire to appear good through the study, all of which can affect the accuracy of the reports. Second, this is a cross sectional close-ended questionnaire and survey. This limits its ability to assess the actual temporal relationship between clinical interventions, the most popular methods used by participants to deal with depression, and the level of pastoral care provided by the church organization. Another limitation that demonstrated the conservative position of participants was the small number of participants in this study. The number was smaller than anticipated, although from the beginning it was established that a minimum of 40 participants were required. This was probably because of the

general perceptions of mental health disorders among this population, or perhaps because the glimpse of the questionnaire that was provided to potential participants may have discouraged the participation of some. It is unknown if the pastors who self-selected to participate in the study satisfactorily represent Hispanic pastors in the southeast region of the Church of God.

This study is quantitative. It relied on responses and analyzed percentages to answer each of the research questions, but still limited the length of the responses to only a fraction of data that can be used to analyze the phenomena of depression. The study utilized descriptive statistics, briefly describing, and summarizing the data from a sample of a specific population. The study would have been more beneficial if it had also employed a semi-structured in-depth interview, but the use of interviews may have minimized the participation in the study.

One of the biggest limitations for this study was the resistance of pastors to explore potential depression symptoms. If the church had been better prepared and educated about depression, prevention mechanisms, and clinical alternatives to assisting pastors in their emotional problems, it would have facilitated the study.

Another immense limitation that arose in the study process was the limited scholarly and popular literature regarding medical, spiritual, and psychological research about depression in Hispanic pastors. Only limited documents that related to causes, case studies, severity of the impact of depression, and treatment for Hispanic pastors were clinically elaborated. The study relied on being able to balance and incorporate into the study personal observations, literature review, biblical perspective, and medical and spiritual views on the problem.

A further limitation emerged from the worldwide effects of the COVID-19 pandemic. The study was initially designed to administer the questionnaire and the survey in the presence of a group of Hispanic pastors during one of the regional assemblies of the southeast. Due to the significant confinement the population was obligated to maintain, the questionnaire and the survey were administered using software and by sending a link to all the active participants. It was necessary to schedule a meeting before sending the link to provide important information related to the invitation to participate in the study. However, due to the unusual situation during the pandemic, this part of the process was difficult. On the other hand, the use of the software brought some benefits for the study such as facilitating participation of respondents despite the multiple pastoral duties, saving some resources since the administration was via a link, and reinforcing confidentiality which was an essential part of the study.

Unexpected Observations

Initially, the study was to explore and theorize about the possible causes of depression among the Hispanic pastors of the Church of God Southeast Region and how these phenomena impact their lives and ministry. The discovery that the active participants' lifestyles are not only impacted by depression but are also likely to cause depression was unexpected. From there, the study started to focus on the respondents' perception of ministers in relation to their understanding of depression, how they have been dealing with it, and how depression has impacted their lives and ministry.

Another interesting observation that worked against the completion of the study was the resistance to participate in the study. There were 439 ministers with credentials in the southeast region with 109 currently pastoring a church. The participants gradually

gained confidence and security from their participation in the study, to the point that the researcher began to receive calls from ministers inquiring about additional information about the study and possible treatments to deal with depression.

Another significant observation from the findings was the low percentage of thoughts of suicide reported in the BDI II test. According to general statistics, thoughts about death and suicide are generally linked with depression. Surprisingly for this researcher, the reported percentage was only 2.08%, meaning only 1 out of the 47 active participants reported having suicidal thoughts but would not carry them out.

The active participants' responses also provided some significant data related to the conceptualization of depression. Participants easily confused the concepts of cause and effect of depression. Other answers were markedly influenced by the pastoral experience and general knowledge obtained from their daily pastoral duties. Some participants preferred not to respond to sensitive questions, perhaps because they do not know the answer or because they do not want to see the reality of the answers. Still, most respondents were able to respond to the research questions.

Recommendations

From the beginning, the focus of the study was to enhance the church organization's involvement in a more specialized pastoral care ministry. It is important to equip Hispanic pastors of the Church of God Southeast Region and their ministries with resources that consider both Scripture and clinical requirements and show how to cope with major depression disorder.

Through the ministry of pastoral care, there should be structured education programs to prepare Hispanic pastors for the ministry, including administration training,

leadership preparation, and methodology to develop coping mechanisms to work under the pressure generated by pastoral duties. Educational processes and training opportunities for pastors are the correct way for them to obtain a better understanding of depression from the clinical perspective. This training is essential to get appropriate and healthy responses from pastors. The consequence of it will be a healthier congregation and a positive impact on the pastoral community.

A larger study which combines clinical intervention and spiritual nourishment is necessary. The larger study would explore issues related to prevention, treatment, and recovery of the severity impact of major depression disorder. The scope of this study should be expanded by conducting research and creating new input on a topic widely discussed in the literature but leaving aside the demographic variability.

Postscript

Without realizing it, depression has interfered in our daily lives, in our social interactions, emotional stability, and in our capacity to respond to daily challenges. The Hispanic pastoral community has experienced the prevalence of depression. Still, depression is stigmatized, especially in our communities, leading to adverse results and inappropriate responses. Part of the problem lies in the limited number of Hispanic ministers of the church open to explore their experience with depression, and to participate in surveys as displayed in this study. Additionally, conservative perspectives have been a big obstacle to using professional methods to counter depression.

The study has been able to explore and highlight how Hispanic pastors of the Church of God Southeast Region perceive depression and those factors that contribute to its presence affecting their lives and ministry. It is hoped that the findings and

recommendations offered in this study will be beneficial for the Hispanic pastoral community to identify the best ways to educate and help pastors to cope with major depression disorder. The desire to educate our communities can be seen as a call for our ecclesial organization to make a structural and attitudinal change and to address this problem of depression in a practical and proactive manner. The field is still open to continue the exploration.

APPENDIX A

Demographic Questionnaire and Participant Characteristics

1. What is your age?

   ☐ 18-25 ☐ 26-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60 or older

2. What is your gender?

   ☐ Male ☐ Female

3. What is your ethnic background?

   ☐ Black/African American

   ☐ White/Caucasian

   ☐ Hispanic/ Latino

   ☐ Arab/ Middle Eastern

   ☐ Asian/Pacific Islander

   Other (Please specify)

4. What is your current marital status?

   ☐ Married

   ☐ Single

   ☐ Divorced

   ☐ Separated

   ☐ Widowed

5. What is the highest level of education you have completed?

☐ Doctoral degree

☐ Master's degree

☐ Bachelor's degree

☐ Associate degree

☐ Some college

☐ Vocation / Technical school

☐ High School or Equivalent

☐ Grammar School

Other (Please Specify)

6. Numbers of years in Ministry?

☐ Less than 12 months

☐ 1-5 years

☐ 6-10 years

☐ 11-15 years

☐ 16-20 years

☐ Over 20 years

7. Are you currently pastoring?

☐ Yes

☐ No

8. Which of the following best describes the area where you live in?

☐ Rural (Town population below 6.000)

☐ Suburban (City/Town population between 6000-89.000)

☐ Urban (City population over 90.000)

9. Which of the following best describes the area you attend church?

☐ Rural (Town population below 6.000)

☐ Suburban (City/Town population between 6000-89.000)

☐ Urban (City population over 90.000)

10. How often do you refer parishioner, members of your congregation, or others for mental health counseling?

☐ None in the past 2 years

☐ 1-5 times in the past 2 years

☐ 6-10 times in the past 2 years

☐ 11-15 times in the past 2 years

☐ Over 15 times in the past 2 years

☐ Never

Other (Please specify)

11. Have you ever experienced depression?

☐ Yes

☐ No

12. How often do you feel depressed?

☐ Always

☐ Sometimes

☐ Not often

☐ Never

13. Have you ever received Mental Health Counseling for Depression?

☐ Yes

☐ No

14. Have you ever received counseling from another member of the clergy?

☐ Yes

☐ No

15. Have you ever been prescribed medication for depression?

☐ Yes

☐ No

16. Do you think that it is appropriate for a Christian to use medication to treat depression?

☐ Yes

☐ No

17. Have you felt burned out within the first five years of your ministry?

☐ Yes

☐ No

18. Have you needed to take a leave of absence from your ministry because you felt overwhelmed with your congregation?

☐ Yes

☐ No

19. Have you continued pastoral duties even knowing you are experiencing depression?

☐ Yes

☐ No

20. In the past or currently, have you looked for *professional* help when experiencing depression?

☐ Yes

☐ No

21. If your answer to the previous question was “yes”, who have you visited?

☐ Psychologist

☐ Psychiatrist

☐ Medical doctor

☐ Mental Health Counselor

☐ Others

22. In your opinion, what do you think are the cause(s) of Depression among pastors?

☐ Family issues

☐ Stress and Burnout in Ministry

☐ Finance

☐ Excessive drug or alcohol use

☐ Lack of exercise

☐ Self-pleasure and/or sexual habits

☐ Loneliness or isolation

☐ Demonic influence

☐ A rundown physical condition

☐ Other

23. In your opinion, what is the most important symptom of a pastor experiencing Depression?

☐ Feeling of hopeless, helpless and guilt

☐ Loss of interest or pleasure in hobbies/activities that were once enjoyed

☐ Feeling that you have a lot to look forward to

☐ Feeling trapped with not options

☐ Feeling that you've lost control of your life and future

☐ Feeling overwhelmed

☐ Decrease of energy and fatigue

☐ Insomnia or excessive sleep

☐ Appetite and/or weight loss or overeating and weight gain

☐ Thoughts of death and/or suicide attempts

☐ Restlessness and irritability

☐ Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

24. What enables you to cope best with the stress of pastoral work?

☐ Do nothing or just ignoring it

☐ Reading the Bible

☐ Praying

☐ Reflecting

☐ Talking to a friend

☐ Get counseling

☐ Antidepressant and medicaments

25. Taking in consideration health, social relationships, productivity, suicide and dependency. What do you think is the most negative effect of experiencing depression?

_____

_____

_____

_____

_____

_____

26. How do you think depression can impact the life of a Hispanic pastor?

_____

_____

_____

_____

APPENDIX B

Beck Depression Inventory Test II

1. Sadness
    0 I do not feel sad.
    1 I feel sad much of the time.
    2 I am sad all the time.
    3 I am so sad and unhappy that I can't stand it.
2. Pessimism
    0 I am not discouraged about my future.
    1 I feel more discouraged about the future that I used to.
    2 I do not expect things to work out for me.
    3 I feel the future is hopeless and will only get worse.
3. Past Failure
    0 I do not feel like a failure.
    1 I feel I have failed more than I should have.
    2 As I look back on my life, all I can see is a lot of failures.
    3 I feel I am a total failure as a person.
4. Loss of Pleasure
    0 I get as much as much pleasure as I ever did from the things I enjoy.
    1 I don't enjoy things the way I used to.
    2 I get very little pleasure from the things I used to enjoy.
    3 I can’t get any pleasure from the things I used to enjoy.
5. Guilty Feelings
    0 I don't feel particularly guilty.
    1 I feel guilty over many things I have done or should have done.
    2 I feel quite guilty most of the time.
    3 I feel guilty all of the time.
6. Punishment feelings
    0 I don't feel I am being punished.
    1 I feel I may be punished.
    2 I expect to be punished.
    3 I feel I am being punished.
7. Self-Dislike
    0 I feel the same about myself as ever.
    1 I have lost confidence in myself.
    2 I am disappointed in myself.
    3 I dislike myself.
8. Self-Criticalness
    0 I don't criticize or blame myself more than usual.
    1 I am more critical of myself than I used to be.
    2 I criticize myself for all of my faults.
    3 I blame myself for everything bad that happens.

9. Suicidal thoughts or Wishes
    0 I don't have any thoughts of killing myself.
    1 I have thoughts of killing myself, but I would not carry them out.
    2 I would like to kill myself.
    3 I would kill myself if I had the chance.
10. Crying
    0 I don't cry any more than I used to.
    1 I cry more now than I used to.
    2 I cry over every little thing.
    3 I feel like crying, but I can't.
11. Agitation
    0 I am no more restless or wound up than usual.
    1 I feel more restless or wound up than usual.
    2 I am so restless or agitated, it's hard to stay still.
    3 I am so restless or agitated than I have to keep moving or doing something.
12. Loss of Interest
    0 I have not lost interest in other people or activities.
    1 I am less interested in other people or things than before.
    2 I have lost most of my interest in other people or things.
    3 It's hard to get interested in anything.
13. Indecisiveness
    0 I make decisions about as well as I ever.
    1 I find it more difficult to make decisions than usual.
    2 I have much greater difficulty in making decisions than I used to.
    3 I have trouble making any decision.
14. Worthlessness
    0 I don't feel I am worthless.
    1 I don't consider myself as worthwhile and useful as I used to
    2 I feel more worthless as compared to others.
    3 I feel utterly worthless.
15. Loss of Energy
    0 I have as much energy as ever.
    1 I have less energy than I sued to have.
    2 I don't have enough energy to do very much.
    3 I don't have enough energy to do anything.
16. Changes in sleep pattern
    0 I have not experienced any change in my sleeping.
    1a I sleep somewhat more than usual
    1b I sleep somewhat less than usual.
    2a I sleep a lot more than usual.
    2b I sleep a lot less than usual.
    3a I sleep most of the day.
    3b I wake up 1-2 hours early and can't get back to sleep.
17. Irritability
    0 I am not more irritable than usual.
    1 I am more irritable than usual.
    2 I am much more irritable than usual.
    3 I am irritable all the time.

18. Changes in Appetite
    - 0 I have not experienced any change in my appetite.
    - 1a My appetite is somewhat less than usual.
    - 1b My appetite is somewhat greater than usual.
    - 2a My appetite is much less than before.
    - 2b My appetite is much greater than usual.
    - 3a I have no appetite at all.
    - 3b I crave food all the time
19. Concentration difficulty
    - 0 I can concentrate as well as ever.
    - 1 I can't concentrate as well as usual
    - 2 It's hard to keep my mind on anything for very long.
    - 3 I find I can't concentrate on anything.
20. Tiredness or Fatigue
    - 0 I'm not more tired or fatigued than usual.
    - 1 I get more tired or fatigued more easily than usual.
    - 2 I'm too tired or fatigued to do a lot of the things I used to do.
    - 3 I'm too tired or fatigued to do most of the things I used to do.
21. Loss of interest in sex
    - 0 I have not noticed any recent change in my interest in sex.
    - 1 I'm less interested in sex than I used to be.
    - 2 I'm much less interest in sex now.
    - 3 I have lost interest in sex completely.

APPENDIX C

Consent for Participation in Test Research

You are invited to be in a research study being done by Dr. Nelson Parra Jerez a doctoral student from Asbury Theological Seminary. You are invited because you are a minister of the Church of God southeast region Hispanic ministry.

I understand that the project is designed to gather information about Major Depressive disorder. I will be one of approximately 439 people being tested for this research.

1. My participation in this project is voluntary. I understand that I will not be paid for my participation. I may withdraw and discontinue participation at any time without penalty. If I decline to participate or withdraw from the study, no one will be told.

2. If I feel uncomfortable in any way during the test session, I have the right to decline to answer any question or to end the test.

3. The test will last approximately 10-15 minutes.

4. I understand that the researcher will not identify me by name in any reports using information obtained from this test and that my confidentiality as a participant in this study will remain secure. Subsequent uses of records and data will be subject to standard data use policies which protect the anonymity of individuals and institutions.

5. Bishops, Administrators or leaders from my denomination will not have access to raw notes or transcripts. This precaution will prevent my individual comments from having any negative repercussions.

6. I understand that this research study has been reviewed and approved by the Institutional Review Board (IRB) for Studies Involving Human Subjects: Behavioral Sciences Committee at the Asbury Theological Seminary. For research problems or questions regarding subjects attached to this study, the researcher Nelson Parra Jerez may be contacted through email at nelson.parra@asburyseminary.edu.

7. If at any time during or after my participation on the study I feel the need to talk to someone or contact professional clinical counseling services, I may call (407)405-8090 for consultation.

8. I have read and understood the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.

My Signature Date

_____ Date signed_____

Signature of Person Agreeing to be in the Study

For further information, please contact:

Dr. Nelson Parra Jerez

APPENDIX D

Confidentiality/Authorization Letter

Dr. Otoniel Collins Junio de 2020,
2020
Obispo Administrador
IGLESIA DE DIOS REGION SURESTE HISPANA

Estimado y apreciado Obispo Otoniel Collins, le saludo en nombre de nuestro Señor Jesucristo.

Como ya es de su conocimiento, actualmente me encuentro desarrollando los requisitos académicos del programa de DMin, Doctorado en Ministerio en el Seminario ASBURY. El tema de la disertación es "**Dealing with Depression. Factors that contribute to the presence of Major Depression Disorder and its impact in Hispanic Pastors of Church of God**". Debo de antemano reiterar mis agradecimientos a su inmenso apoyo dentro de este proceso académico y de ministerio, apoyo el cual comenzó desde el año 2015 con la anterior administración.

La Disertación y el trabajo de investigación son requisito indispensable para obtener el título DMin, cuya graduación está proyectada para el mes de mayo de 2021. Confío en el Señor usted pueda participar, ya que otros pastores colegas de nuestra organización y región estarán graduando.

Este proceso requiere que realice los procedimientos académicos (teóricos y prácticos), para evaluar los conocimientos que nuestros pastores tienen acerca de "Major Depression Disorder". También, medir los actuales síntomas de depresión al interior del equipo pastoral de nuestra región sureste hispana de la Iglesia de Dios. Estos procedimientos no implican de modo alguno un diagnóstico clínico individual o de resultados que comprometan en alguna manera a algún pastor, ministro o grupo de ministros en particular, como tampoco a nuestra organización.

Asimismo, ningún ministro estará obligado a participar, pues la realización de los dos instrumentos a ser administrados (Cuestionario sobre datos demográficos y el Beck Depression Inventory test) serán voluntarias y de carácter orientativo. Lo que se pretende es solamente un trabajo estadístico y de descripción. Ningún participante deberá proveer información personal que no esté dispuesto(a) a proveer, como tampoco estará obligado a identificarse o mencionar datos personales que lo comprometan de alguna forma.

De mi parte, y de acuerdo a lo que hemos conversado anteriormente, me comprometo delante del Señor y de nuestra organización, La iglesia de Dios, de la cual soy Obispo Ordenado, a no utilizar la información o datos colectados que resulten de este estudio, para otro propósito distinto a aquel que sea necesario para los requisitos de grado de este programa de doctorado con el Seminario ASBURY.

De la misma forma, debo solicitarle tener en cuenta que la anterior administración bajo el Obispo Angel Marcial, fue debidamente notificada de este proceso, quien en su momento me otorgo la autorización para continuar con este estudio bajo las condiciones establecidas anteriormente. Adjunto dicha autorización.

Debo expresar mi profunda gratitud por su gestión realizada como Obispo Administrador de nuestra región, y que este tipo de logros que algunos de nosotros, pastores, quienes formamos parte del programa de doctorado en ministerio con el seminario Asbury, son también el resultado de su aporte como líder de la región.

Cualquier duda, y/o sugerencia, será tenida bien en cuenta.

Dios te bendiga,

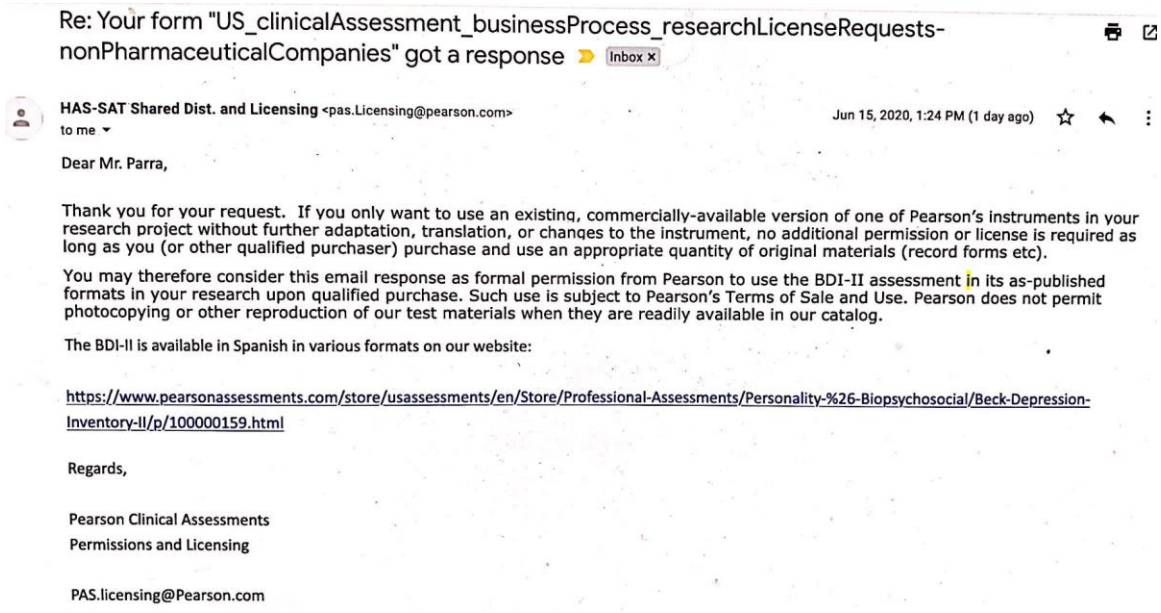
Su Hermano en Cristo

NELSON PARRA JEREZ
Pastorvirtual@live.com
(407)405-8090

Dr. OTONIEL COLLINS
(Constancia de recibo)

APPENDIX E

Beck Depression Inventory Test II Permission



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