PASTORAL CARE FOR MENTAL HEALTH FOR THE SOUTH ASIAN COMMUNITY IN NORTH AMERICA

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Abstract

Pastoral Care for Mental Health for the South Asian Community in North America

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This doctoral project emerges from my personal and pastoral concern for the mental health challenges faced by South Asian (SA) communities in North America. Within many of these communities, mental health continues to be stigmatized, misunderstood, or ignored, often interpreted as a sign of spiritual weakness, moral failure, or a source of shame for the family. Through my ministry experience, I have witnessed how these beliefs, combined with migration stress, cultural expectations, and limited access to culturally competent care, prevent individuals from seeking help, leading to unnecessary suffering.

This project's purpose is to equip pastors, church leaders, and congregations to better understand and respond to mental health needs within their communities. I seek to develop a pastoral care model that integrates spiritual practices with psychological and medical insights, moving beyond approaches that rely solely on prayer or spiritual deliverance. By fostering awareness and reducing stigma, I aim to help churches become safe and supportive spaces where individuals can openly address their struggles and pursue holistic healing.

This study engages theological reflection, cultural analysis, and current mental health research to construct a framework that is both biblically grounded and culturally relevant. Particular attention is given to the influence of honor and shame dynamics, as well as the gaps in pastoral training that often leave leaders unprepared to address mental health concerns effectively.

As part of this project, I propose practical ministry strategies, including training programs, educational workshops, and partnerships with mental health professionals. These initiatives are designed to help church leaders recognize signs of distress, offer appropriate care, and guide individuals toward professional support when needed.
My hope is that South Asian churches transform into communities that reflect God's care for the whole person—spiritually, emotionally, and psychologically—and that this model can be adapted to serve similar communities globally.

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Table of Contents

List of Figures

Part One

Ministry Context

Introduction

The objective of this doctoral research is to enhance and progress education on mental health and to diminish the stigmatization of South Asians (SA) seeking mental health issues treatment, particularly among pastors, church leaders, and congregations. This research aims to improve the understanding of SA churches about mental health care and provide services aligned with the spiritual, psychological, and emotional needs of the congregants by building a responsive community trained to identify and support individuals experiencing mental health issues.

Statement of the Challenges

Many South Asian communities suffer from a severe lack of mental health awareness because of stigma, misconceptions, and knowledge deficits that run exceptionally deep in these cultures.[1] Psychological illnesses, such as anxiety, stress, and depression, are still relatively not well understood in the South Asian context. A person with a mental health condition is typically ostracized as having a poor character or being a coward.[2] The pressure SA's experience to conform to what is deemed "normal" and act and think in traditional ways also influences these issues. Many SA's who discover they have mental health issues do not seek treatment because of the stigma in SA culture.

[1] SAMHIN, "The South Asian Population & Mental Health | SAMHIN," SAMHIN, 2016, https://samhin.org/south-asian-culture-and-mental-health/.

[2] Mike W. Martin, *From Morality to Mental Health: Virtue and Vice in a Therapeutic Culture* (Cambridge: Oxford University Press, 2006).

Attitudes toward mental health issues are based on tradition and folklore, such as the belief in some cultures that evil spirits or ancestral curses cause mental illness. Conditions like depression or anxiety are seen as sins of commission and omission. Therefore, individuals do not seek medical help but silently and needlessly suffer.[3] This perception changes the emphasis from care and cure to stressing appropriate behavior, punishment, or censure. Mental health problems are sometimes regarded as an SA's deficiencies or shortcomings, which they are expected to cope with on their own as opposed to an actual health condition.

Additionally, systemic barriers such as limited access to culturally competent mental health resources and services further compound the problem. Many SA churches are migrant churches, and the struggles of migration, including cultural displacement, language barriers, and an inferiority complex, add to the complexities of mental health stigma, making it even more difficult for individuals to seek support. These barriers stem from (1) the SA community's lack of exposure to mental health care, (2) the communication barrier between the language many SA families speak at home and the language of the mental health professional, and (3) a cultural malaise that prevents a trusting relationship. Cultural malaise often arises from deeply ingrained societal stigmas, misconceptions, and historical mistrust, which hinder open communication and mutual understanding. These barriers cause harm and increase needless suffering. In particular, immigrants already experience acculturation stress and identity crises, as well as

[3] Tayyaba Rehman, "Social Stigma, Cultural Constraints; They're Very Different: Health and Social Care in the Community," Columbia Undergraduate Journal of South Asian Studies 12, no. 5 (2020): 414-421.

structures of society that may push them even further away from accessing valuable resources.

Within the context of SA congregations, particularly in North America, the stigma around mental health is magnified. Cultural imprints and the absence of church leaders who understand mental illness create essential deficits in the system for these communities.[4] As a result, SA churches struggle to provide mental health care. For example, pastors may not know how to identify mental illness symptoms in a congregant or may unconsciously perpetuate stigma by attributing mental health challenges to sin in a person's life or a lack of faith.

In addition, the cultural norms and theological influences named above in SA churches make it even more challenging to fight for the eradication of mental health stigma. Two types of expressions of Christian faith are particularly popular in these communities: Pentecostal and Evangelical. Both types tend to spiritualize mental health, believing that mental illness is a spirit that needs to be prayed for or cast out. While these strategies can sometimes be helpful, they have little, if any, focus on an individual's psychological and medical health.[5] If a balance between spiritual practices (such as prayer and deliverance) and psychological and medical approaches to mental health is not achieved, it is difficult for churches to offer compendious ministry where all the

[4] Blake Victor Kent et al., "Religion and Spirituality among American Indian, South Asian, Black, Hispanic/Latina, and White Women in the Study on Stress, Spirituality, and Health," *Journal for the Scientific Study of Religion* 60, no. 1 (December 22, 2020): 198–215.

[5] Curtis S. Lehmann et al., "Hospitality towards People with Mental Illness in the Church: A Cross-Cultural Qualitative Study," *Pastoral Psychology* 71, no. 1 (October 29, 2021): 1–27.

necessities of one's spiritual, mental, and physical well-being can be fulfilled according to the Word of God and psychology.[6]

The stigma inhibits open discussions around mental health and creates an environment where individuals feel isolated and unsupported, keeping their mental health issues a secret. Individuals struggling with mental health conditions may feel shame about their position in the church or fear gossip among church members. Research by the South Asian Population & Mental Health (SAMHIN) illustrates the dangers of isolation and shame; for instance, Asian American females, who are often disproportionately impacted by stigma, gossip, and cultural pressures, have the highest suicide rates among all racial and ethnic groups.[7] The research suggests that feelings of isolation can result in absence from church activities, sour relations in families, or worse, result in a psychotic break, suicidal ideation, or suicidal intent. These are compelling reasons for SA churches to reconsider their approach to mental health.[8]

Another factor to consider is that churches, through their communal life and activities, provide a safe space for individuals to openly share their mental health struggles and receive prayer.[9] Such environments would reduce stigma and create and encourage discussion of mental health issues. Pastors and church leaders can offer

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[6] Giancarlo Lucchetti, Harold G Koenig, and Alessandra Lamas Granero Lucchetti, "Spirituality, Religiousness, and Mental Health: A Review of the Current Scientific Evidence," World Journal of Clinical Cases 9, no. 26 (September 16, 2021): 7620–31, https://doi.org/10.12998/wjcc.v9.i26.7620.

[7] SAMHIN, "The South Asian Population & Mental Health | SAMHIN," 2016.

[8] Ibid.

[9] Christopher E. M. Lloyd, Brittney S. Mengistu, and Graham Reid, "'His Main Problem Was Not Being in a Relationship with God': Perceptions of Depression, Help-Seeking, and Treatment in Evangelical Christianity," *Frontiers in Psychology*, 13.

favorable conditions for reform in the church by providing the necessary resources to bring about reform. Christopher E. M. Lloyd, Brittney S. Mengistu, and Graham Reid report that addressing this challenge can improve mental health outcomes by reshaping harmful theological perceptions, encouraging help-seeking behaviors, and fostering greater acceptance of professional treatment within church communities.[10]

New attitudes towards mental health issues and alleviating stigma can turn SA churches into empowering spaces that model God's care for the entire person. Wisdom from theologians such as Augustine, Thomas Aquinas, and C. S. Lewis suggests that Christians can assist in building a platform for church leaders to receive mental health awareness training through conferences, seminars, and counselors.

Moreover, the church's role in addressing mental health extends beyond individual congregants. Churches can make a stand against mental health stigma and can set an example for the SA population to pay attention to mental health issues, which can potentially shift cultural attitudes. This cultural change would ensure that more individuals are willing to seek assistance, which in turn would provide more people with treatment for their mental health, hence eradicating the future effects of untreated mental health diseases.

[10] Christopher E. M. Lloyd, Brittney S. Mengistu, and Graham Reid, "'His Main Problem Was Not Being in a Relationship with God': Perceptions of Depression, Help-Seeking, and Treatment in Evangelical Christianity," *Frontiers in Psychology*, 13.

Purpose and Goals of the Project

This purpose of this project is to empower South Asian churches to become proactive advocates for mental health, addressing a critical yet underexplored need within their communities. Across SA cultures and religious beliefs, mental health problems are still widely vilified, misapprehended, or ignored. These views and attitudes bring about prejudices, unchecked mental illnesses, and limited discussion about mental health—which cause harm to individuals and communities. Since churches are focal institutions in every community and people entrust them with many issues, they present an ability to transform cultures and spread concern and care.

The primary aim of this project is to educate pastors and church leaders in South Asian contexts in the U.S. to identify and address mental health issues within their congregations. Mental health training programs can provide these leaders with baseline knowledge for identifying signs of distress, offering initial support to a distressed person, and knowing how and when to refer a person to a healthcare professional. Education can also improve how European church leaders respond to caregivers' psychological aspects of their work since the two notions are intertwined.

Reducing stigma is another crucial goal. In SA communities, mental health struggles are often seen as weaknesses or failures, creating an environment of silence and shame. When these myths are discredited, people will hopefully turn to the church and discuss their mental health. Actual applications of this endeavor include preaching focused on mental health issues and educational opportunities that inform congregants

about people's experiences with mental health disorders.[11] These initiatives can also help create awareness of gender differences, promoting inclusivity and acceptance of the LGBTQIA+ community while working to end stigma and prejudice without implying that gender identity or sexual orientation are mental health conditions.

This project also seeks to create sustainable mental health support systems within the church. This includes establishing support groups, forming links with mental health workers, and incorporating mental health issues into church activities (i.e., teaching the congregation techniques to cope with stress, grief, and depression), such as during Bible study or fellowship time.[12] These efforts can help the church more proactively address mental health issues.

A broader aim of the project is to establish a replicable model for reducing the stigma around mental health care that can be implemented in other South Asian churches and, potentially, in different cultural contexts. By experimenting with this approach in select churches, data will be collected, including information on SA experiences to improve mental health awareness and care. The project's ultimate goal is to develop matrices applicable across different contexts of SA churches globally to maintain and strengthen the church's influence on mental health issues.

[11] Ahad Ahmed, Marcos Gonzalez, and Patricia Junquera, "Understanding and Addressing Mental Health Stigma across Cultures for Improving Psychiatric Care: A Narrative Review," *Cureus* 15, no. 5.

[12] Ibid.

Preview of the Project

This project is structured into two main sections: (1) Ministry Context (chapter 1) and (2) Literature Review (chapter 2), Theology (chapter 3), Ministry Practice (chapter 4), Implementation and Assessment (chapter 5).

This project is structured into three parts. Part one contains the ministry context, with an introduction to the project and chapter 1. Part two is the theological reflection, where I provide in chapter 2 the literature review, followed by a theological review in chapter 3 and a review of my ministry practice in chapter 4. Part three presents my ministry strategy, including in chapter 5 my project implementation and assessment.

In chapter 1, I define the plan for teaching the congregation about mental health and efforts against stigma in SA churches, including how to prepare the churches to address the holistic health needs of their congregations. In this chapter, I explore the demographic, cultural, and organizational profiles of South Asian people in the church milieu. Some churches also act as focal points in society because they shape people's social morality. Some of the issues discussed in chapter 1 concern the cultural prejudices and misconceptions of faith that deny people the opportunity to seek mental health treatment. In demographic terms, SA Christians in North America represent a church with immigrant backgrounds, different generations, and uneven economic status. Some of the congregation members face special issues like acculturation stress, racism, and intergenerational conflict, which often worsen mental health issues.[13] These dynamics

[13] David R. Williams, "Stress and the mental health of populations of color: Advancing our understanding of race-related stressors," *Journal of Health and Social Behavior* 59, no. 4 (2018): 466-485.

suggest the need for pastoral care that transcends spiritual counseling in preserving cognitive health.

Culturally, the stigma attached to mental health is deeply rooted in traditional beliefs, often framing mental illness as a sign of moral or spiritual failure. This view not only prevents a person in need from seeking help but also causes them to experience loneliness, guilt, and shame.[14] There is low awareness and training among the pastors and leaders of the SA church such that they possibly inadvertently perpetuate that stigma. Additionally, addressing questions and concerns around theodicy is important in SA contexts; SA churches prefer prayer, faith, and spiritual deliverance as the central strategies in combating personal suffering, leaving psychological and medical treatments out of consideration. Therefore, in this chapter, I emphasize that mental health education within a pastoral care setting is crucial in allowing the congregation to seek help without fear or prejudice. These aspects are discussed, and key issues are contextualized to discover a more comprehensive approach to addressing the stigma against mental health in SA congregations.

In chapter 2, I engage with scholarly and theological perspectives to establish a framework for addressing mental health within SA churches. I employ best practices, ethnography, and theological values to develop strategies. I review literature on cultural attitudes that are significant to mental health. For example, research shows that in SA cultures of shame or honor, societal prejudice against mental health is evident. Authors

[14] Mao-Sheng Ran, Brian J. Hall, Tin Tin Su, Benny Prawira, Matilde Breth-Petersen, Xu-Hong Li, and Tian-Ming Zhang, "Stigma of mental illness and cultural factors in Pacific Rim region: a systematic review," *BMC Psychiatry* 21 (2021): 1-16.

like Zamira Hyseni Duraku et al. investigate the effects of stigma on seeking help and the need to reduce prejudice in youth.[15] Likewise, Xiao Yang et al. examine the relationship between mental health knowledge and perceived prejudice and show that enhancing mental health knowledge helps to prevent prejudice while enhancing seeking professional psychological treatment.[16]

Another prominent theme in the literature is the church as part of a more extensive support system. Simon Dein acknowledges faith communities' participation in meeting mental health demands in the past and how they can help improve comprehension and acceptance.[17] In their review of spiritual care, Guangwei Zhang, Qiyu Zhang, and Fan Li explore the effect of psychological well-being and show how faith can enhance one's overall well-being.[18] These perspectives corroborate how the church is strategically positioned to change mindsets and demeanor within the SA population for the "uplifted" spiritual and "down-trodden" psychological needs. Measures to eliminate prejudice and increase mental health awareness are also discussed. Strategies are considered adequate if they are educational workshops, support groups, and work with

[15] Duraku Zamira Hyseni, Holly Davis, Artë Blakaj, Arjeta Ahmedi Seferi, Klea Mullaj, and Viola Greiçevci, "Mental Health Awareness, Stigma, and Help-Seeking Attitudes among Albanian University Students in the Western Balkans: A Qualitative Study," *Frontiers in Public Health* 12 (September 4, 2024).

[16] Xiao Yang et al., "The Relationship between Mental Health Literacy and Professional Psychological Help-Seeking Behavior among Chinese College Students: Mediating Roles of Perceived Social Support and Psychological Help-Seeking Stigma," *Frontiers in Psychology* 15 (June 13, 2024).

[17] Simon Dein, "Religious Healing and Mental Health," *Mental Health, Religion & Culture* 23, no. 8 (September 13, 2020): 657–65.

[18] Guangwei Zhang, Qiyu Zhang, and Fan Li, "The Impact of Spiritual Care on the Psychological Health and Quality of Life of Adults with Heart Failure: A Systematic Review of Randomized Trials," *Frontiers in Medicine* 11 (April 17, 2024): 1334920.

mental health professionals.[19] According to a study by Amira E. Abd El Salam et al., significant behavioral changes can be obtained from health education programs on mental health knowledge and attitude among adolescents, and church-related programs aimed at similar positive behavioral change can adopt this strategy.[20] Additionally, Winifred Ekezie et al. provide a framework for implementing behavioral change techniques within minority populations, offering valuable insights into how churches can adapt interventions to increase engagement and acceptance.[21]

The literature review also exposes gaps in knowledge, including the lack of culturally appropriate programs for mental health administration in SAs from religious and cultural backgrounds. Thus, I hope to add to an increasingly small but significant body of scholarship advocating mental health in faith communities.

The success of this project hinges on its ability to navigate the unique cultural dynamics of SA congregations. Culturally relevant practices always consider attitudes toward mental health based on the communities' beliefs, values, and culture. Cultural competency involves the first step of addressing the cultural beliefs regarding mental illness in SA. This results in what may be referred to as the stigma of collectivistic culture, where the act of an individual is seen to be an act of the whole family. Thus, a

[19] Amira E. Abd El Salam, "Significant Behavioral Changes From Health Education Programs on Mental Health Knowledge and Attitude Among Adolescents," *Journal of Adolescent Health* 53, no. 2 (2023): 345-360.

[20] Amira E. Abd El Salam, Amany M. AbdAllah, and Hala A. El Maghawry, "Effect of Health Education Program on Improving Knowledge and Attitude towards Mental Health Stigma and Professional Help-Seeking among Adolescents," *Middle East Current Psychiatry* 30, no. 1 (April 10, 2023): 1–9.

[21] Winifred Ekezie et al., "A Systematic Review of Behaviour Change Techniques within Interventions to Increase Vaccine Uptake among Ethnic Minority Populations," *Vaccines* 11, no. 7 (July 19, 2023): 1259–59, https://doi.org/10.3390/vaccines11071259.

person is forced to hide disclosure of a mental health issue from their family, or their family will be dishonored. The culture-sensitive function erases such concerns due to the focus on the group accountability of mental health and the church's duties as a fellowship.

Cultural awareness also depends on language and communication. Clergy must engage in discussing mental health in the context of a spirituality that does not continue to associate mental health issues with shame. For instance, applying terms like well-being and strength instead of disease and pathology makes dialogue less threatening. Attention also needs to be paid to theological sensitivity. SA churches tend to practice spiritually-based approaches to handling personal problems, and prayer and faith are believed to solve most problems.[22] Though these practices are a part of pastoral care, they cannot be done without psychological or medical intervention. Culturally competent practice merges religious tenets with empirically supported therapies, proving that spirituality and psychiatry need not be adversaries but rather health partners. Last, cultural competency means interaction with the more significant SA population. Partnering with mental health workers who understand cultural dexterity, churches can impact beyond the congregants' families and communities. This makes the interventions both efficient and sustainable as they are being implemented through the cooperation of external and internal stakeholders.

[22] Arpana G. Inman et al., "Cultural Transmission: Influence of Contextual Factors in Asian Indian Immigrant Parent's Experience,'" *Journal of Counseling Psychology* 54 (2007): 93-100.

Definitions of Key Terms

Understanding key terms is essential for discussing mental health and its intersection with religious and social frameworks. The following definitions clarify essential concepts related to mental health, destigmatization, and pastoral care, which are central to addressing mental well-being within faith communities.

Mental Health: Mental health is the state of emotional, psychological, and social well-being that influences how individuals think, feel, and behave. It encompasses coping with stress, maintaining relationships, and making informed decisions throughout childhood, adolescence, adulthood, and elder years.[23]

Destigmatization: Destigmatization involves actively reducing negative stereotypes and prejudices toward individuals with mental health conditions. The perspective is to be able to look, without prejudice, for help with one's problem and receive help without any discrimination.[24]

Pastoral Care: Pastoral care refers to the church's role in providing spiritual guidance, emotional support, and practical assistance to individuals. It includes employing beliefs and religious doctrines that foster the health and welfare of the congregation's members.[25]

Cultural Competence: This term describes the ability to understand, communicate,

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[23] World Health Organization, "Mental Health," World Health Organization (World Health Organization), June 17, 2022, https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response.

[24] Stuart Heather, "Reducing the Stigma of Mental Illness," *Global Mental Health* 3, no. 17 (May 10, 2016).

[25] Randi Synnøve Tjernæs, H. K. Ringnes, and G. Stålsett, "Revisiting Emotions in Pastoral Care and Counseling: A Scoping Review," *Pastoral Psychology* 73, no.

and effectively interact with people across different cultures. It embraces cultural prejudice and practices ways of closing the gap with other cultures.[26]

[26] Michael Davis, "The 'Culture' in Cultural Competence," *Cultural Competence and the Higher Education Sector*, 2020, 15–29.

Chapter 1

Ministry Context

South Asian communities in North America represent a growing and diverse population characterized by their rich cultural heritage and strong religious values. Residents of North America consist of first- and second-generation immigrants from India, Pakistan, Bangladesh, Sri Lanka, and Nepal, who are essential and valuable to North America's culturally diverse societies. Nevertheless, there are special issues affecting this population. For instance, issues of acculturation, conflicts between generations, and mental health disorders are taboo subjects among them.[1] These problems persist because of cultural beliefs and organizational practices, so many people receive no assistance.

Mental health stigma is deeply rooted in traditional SA beliefs and cultural practices.[2] This stigma is usually aggravated by theological misunderstandings, which consider mental disorders as signs of spiritual failure or divine retribution. It is worrisome that such stigma not only discourages one from seeking any help from qualified personnel but also hinders the church as a body from administering complete health solutions that encompass the

[1] Semran K. Mann, Lisa R. Roberts, and Susanne Montgomery, "Conflicting cultural values, gender role attitudes, and acculturation: Exploring the context of reproductive and mental health of Asian-Indian immigrant women in the US," *Issues in Mental health nursing* 38, no. 4 (2017): 301-309.

[2] Jasleen Sing, "Mental health stigma in South Asian communities," Spring 2022, Illinois Psychiatric Society Mind Matters.

spiritual, emotional, and psychological well-being of its members.[3] In this chapter, I review the ministry context among South Asians in terms of their characteristics, culture and beliefs, organizational systems, and stigma. This analysis forms the background on which interventions can be premised for providing mental health education and destigmatization within pastoral care practices for South Asian Christians.

Demographics and Socioeconomic Data

In this section, I explore the growth and distribution of South Asian populations in North America, highlighting their cultural diversity and expanding presence. I include key trends of population size, geographic distribution, and the factors driving immigration, such as skilled labor migration, family reunification, and student immigration.

Overview of South Asian Population in North America

South Asians living in North America are among the most rapidly growing immigrant populations and are vast and culturally diverse. The Asian Pacific Institute on Gender-Based Violence states that this group comprises people from India, Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan, and the diaspora.[4] Together, they account for over

[3] Ahad, Gonzalez, and Junquera, "Understanding and Addressing Mental Health Stigma across Cultures for Improving Psychiatric Care," 1–8.

[4] Asian Pacific Institute on Gender-Based Violence, "Census Data & API Identities," Asian Pacific Institute on Gender-Based Violence Website, July 28, 2017, https://www.api-gbv.org/resources/census-data-api-identities/.

five million United States and Canada residents.[5] This population growth has been occasioned by disparities in skills immigration, family reunion immigration, and student immigration, with active and dynamic populations in urban and suburban areas.

South Asians primarily dwell in large cosmopolitan cities such as New York, Toronto, Los Angeles, and Vancouver. Secondary urban centers include Houston, Dallas, Chicago, and Silicon Valley (California), which offer the inhabitants many professional and economic opportunities. These areas are the cultural hubs for ethnic markets, places of worship, and other organizations that maintain cultures while assimilating into North American society.[6] Despite these concentrations, smaller South Asian populations also emerge in less urbanized areas, reflecting changing economic patterns and migration trends.

According to the 2021 demographic data, Asian Indians constitute approximately 4.8 million of the 24 million Asian American population.[7] While the majority of Asian Indians reside in metropolitan hubs, there is a noticeable dispersion into suburban and less urbanized regions, aligning with broader migration trends observed among other Asian American groups, such as the Chinese (5.4 million), Filipinos (4.4 million), and Koreans (2 million).[8] This shift highlights the increasing presence of South Asians in emerging economic centers beyond traditional immigrant enclaves (see figure 1).

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[5] SAALT, "Demographic Information | SAALT," South Asian Americans Leading Together, 2023.

[6] Rennie Lee, Yue Qian, and Cary Wu, "Coethnic Concentration and Asians' Perceived Discrimination across U.S. Counties during COVID-19," *Socius: Sociological Research for a Dynamic*.

[7] SAALT, "Demographic Information | SAALT."

[8] Ibid.

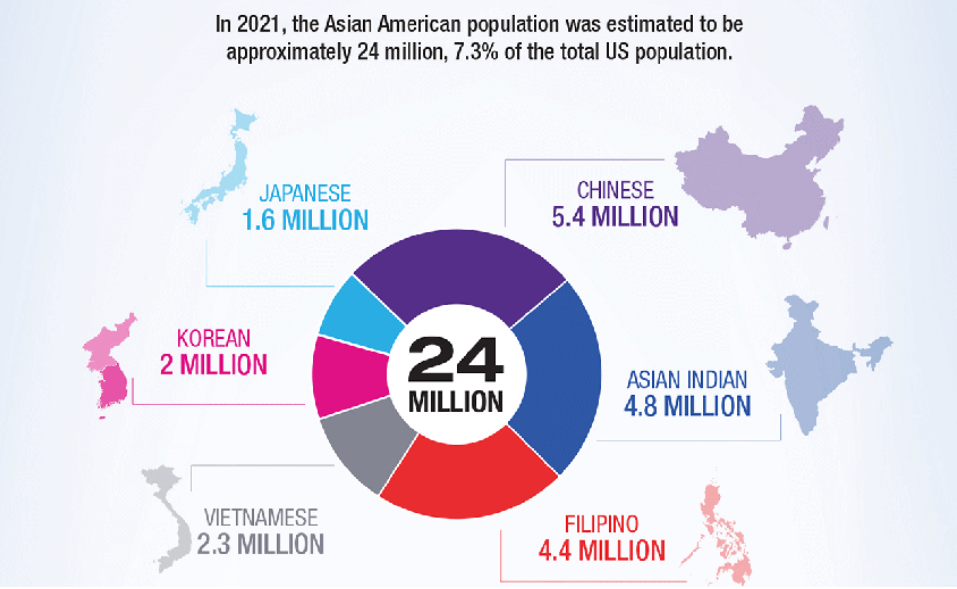

Figure 1. Overview of South Asian Population in North America[9]

Population Size, Geographic Distribution, and Growth Trends

The South Asian population of people in North America who originate from South Asian countries is enormous; population data shows that this number has been skyrocketing over the last two decades. In the United States, most immigrants come from India, with Pakistan, Bangladesh, and Sri Lanka following behind. Canada has witnessed an increase in the number of newly arrived immigrants, most of which can be found in Toronto and Vancouver.[10] According to the 2021 Canadian census, South Asians are the largest visible minority population group in Canada. Among South Asian Canadians, 44.3

[9] Ibid.

[10] Namratha R. Kandula and Alka M. Kanaya, "The South Asian Enigma," *Circulation* 144, no. 6 (August 10, 2021): 423–25.

percent were born in India, 28.7 percent in Canada, 9.2 percent in Pakistan, 5.4 percent in Sri Lanka, and 3 percent in Bangladesh.[11]

As of 2019, 14.1 million Asian immigrants were residing in the United States, representing a 29 percent increase from 1960. Today, people born on the continent of Asia account for 31 percent of the 44.9 million immigrants in the United States.[12] This growth can be attributed to a combination of factors: (1) in the US, skilled labor migration has increased under initiatives like the H1-B visa program, and (2) in Canada, the Federal Skilled Worker Program has contributed to the growth of the immigrant population from Asia.

Additionally, student migration has significantly contributed, with South Asians representing one of North America's largest contingents of international students. Intergenerational growth within established families also accounts for the steady population increase.[13] Notably, South Asian communities are becoming more geographically dispersed. While traditional hubs like New York and Toronto remain prominent, emerging trends show significant population increases in regions such as Texas, the Midwest, and the Pacific Northwest.[14] This shift is influenced by economic opportunities and more affordable living conditions in these areas.

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[11] Buchignani Norman, "South Asian Canadians | the Canadian Encyclopedia," 2018, https://www.thecanadianencyclopedia.ca/en.

[12] Hanna Mary and Batalova Jeanne, "Immigrants from Asia in the United States," March 9, 2021, https://www.migrationpolicy.org/.

[13] Statistics Canada, "Immigration and Ethnocultural Diversity in Canada," May 8, 2018, https://www.statcan.gc.ca/.

[14] Timothy M. Vowles, and Michael Lück, *The Low Cost Carrier Worldwide* (Oxfordshire, UK: Routledge, 2016), 61-78.

Key Countries of Origin

South Asian communities in North America originate primarily from India, Pakistan, Bangladesh, Sri Lanka, and Nepal, with smaller populations from Bhutan and the broader diaspora. India is the primary source of migrants, driven by high education levels and professional qualifications among its emigrants. Pakistani migrants often share similar educational and professional aspirations, contributing to diverse fields like medicine, engineering, and business.[15] Though smaller, Bangladeshi and Sri Lankan communities have recently significantly grown, with many working in IT, healthcare, and academia. Nepali and Bhutanese migrants represent newer groups within the diaspora, often arriving through refugee programs or seeking educational opportunities.[16] These communities bring unique cultural and linguistic diversity, enriching the broader South Asian identity in North America.

Socioeconomic Characteristics

In this section, I examine the income levels, employment sectors, and education attainment of South Asians in North America. I highlight their significant economic success, particularly in high-skilled sectors, and disparities within the community, especially between established families and recent immigrants. Economic barriers such as credential recognition and language challenges affecting newcomers are also explored.

[15] Kandula and Kanaya, "The South Asian Enigma," 423–25.

[16] Natasha R. Matthews, et al., "Health and Socioeconomic Resource Provision for Older People in South Asian Countries: Bangladesh, India, Nepal, Pakistan and Sri Lanka Evidence from NEESAMA," *Global Health Action* 16, no. 1.

Income Levels, Employment Sectors, and Education Attainment

South Asians in North America are often among the most educated and economically successful immigrant groups. In 2022, 61 percent of Asian Americans had achieved a bachelor's degree or higher, compared to the 37.9 percent national average. Asian American men were slightly more likely to have a bachelor's degree than women, with 56.9 percent and 52 percent, respectively.[17] Many are employed in high-skilled sectors such as technology, healthcare, finance, and academia. Asian Indian Americans, in particular, have a median household income significantly higher than the national average, reflecting their concentration in professional fields. However, this economic success is not uniformly distributed across all South Asian subgroups. While many enjoy financial stability, others, particularly recent immigrants, face significant barriers to economic mobility. Asian American households in 2021 had a median household wealth of $206,400, which is not statistically different from White householders.[18] Migrants from smaller South Asian countries like Nepal and Bhutan and certain Bangladeshi and Sri Lankan groups often work in low-wage sectors such as hospitality, retail, and manual labor.

Economic Disparities within the Community

Nevertheless, economic discrimination seems to persist between first-generation immigrants and well-established families in the community. Credential recognition, weak

[17] Dedrick Asante Muhammad and Maya Kurani, "Racial Wealth Snapshot: Asian Americans and the Racial Wealth Divide» NCRC," National Community Reinvestment Coalition, August 23, 2023.

[18] Ibid.

networks, and language barriers cause immigrants and new arrivals to suffer underemployment. For instance, professionals with a college education can end up doing jobs that do not require a college education because of systematized structural barriers. These economic disparities are seen between well-settled and new immigrants and within families. A husband who depends on a visa sponsored by his well-settled wife may experience a heightened sense of inadequacy, particularly if she is more advanced in education, career, or earning capacity. This dynamic can create theological conflict, as traditional gender roles emphasize the husband as the "head of the household," yet he may struggle to fulfil this role due to financial constraints.

Conversely, some husbands may compensate by adopting an authoritarian stance at home, using biblical justification for male leadership, even when their wives, who may have managerial roles, are unwilling to conform due to their wider worldview and economic independence. Similarly, if a wife is financially dependent on her husband but holds progressive views, tensions can arise in decision-making and authority within the household. These conflicts, rooted in both cultural and theological expectations, further impact mental health and family stability.[19] Such differences result in a split society because the new immigrant groups cannot attain the same standards as the pioneer waves of immigrants. To support South Asian communities, filling these gaps that hinder their equity is vital.

[19] Gauri Bhattacharya and Shannon L. Schoppelrey, "Preimmigration Beliefs of Life Success, Postimmigration Experiences, and Acculturative Stress: South Asian Immigrants in the United States," *Journal of Immigrant Health* 6, no. 2 (2004): 83-92.

Access to Healthcare

In this section, I explore how South Asians in North America utilize healthcare services, focusing on mental health care. I examine the factors influencing healthcare access, such as socioeconomic status, education, cultural beliefs, and barriers to seeking mental health treatment. These include affordability, insurance coverage, and pervasive cultural stigma surrounding mental illness.

Current Levels of Healthcare Utilization, Including Mental Health Services

South Asians either significantly utilize high healthcare services or low healthcare services depending on factors such as socioeconomic status (SES), education, and perceived cultural beliefs about using healthcare. South Asians do attend routine healthcare services, but mental healthcare is a largely ignored sector.[20] Research shows that there are discrimination, ignorance, and misconceptions related to mental illness, which dissuades people from seeking treatment.[21] Primary care doctors visited by patients who do seek care are chosen over specialists; thus, mental illnesses often remain undiagnosed and untreated. Those who are most likely not to seek help are women and older people because of the stigma related to mental illness.[22] Younger generations,

[20] Gursharen Virdee, PhD, "Let's talk about mental health in South Asian communities," 2018, CAMH.https://www.camh.ca/en/camh-news-and-stories/lets-talk-about-mental-health-in-south-asian-communities.

[21] Shatabdi Goon and Karen Chapman-Novakofski, "Call for Cultural and Language-Concordant Diabetes Care, Nutrition Education, and Self-Management for South Asian Individuals Living in the US," *Journal of Nutrition Education and Behavior* 55, no. 12 (November 7, 2023).

[22] Alison Karasz et al., "Mental Health and Stress among South Asians," *Journal of Immigrant and Minority Health* 21, no. S1 (November 15, 2016): 7–14.

however, are beginning to challenge these norms, seeking therapy and counseling at higher rates.[23]

Barriers Such as Affordability, Insurance Coverage, and Cultural Stigmas

Barriers such as affordability, insurance coverage, and cultural stigmas significantly impact the utilization of mental health services among South Asians.[24] Many patients avoid seeking care due to the high costs and lack of adequate insurance coverage, which makes mental health services inaccessible. Additionally, cultural stigma remains a critical barrier, as mental illness is often viewed as a personal or family failure. This stigma extends to mental health professionals, who are sometimes seen as unnecessary. Addressing these barriers requires culturally sensitive outreach and education to normalize mental health care and improve access within South Asian communities.[25]

Cultural and Religious Context

In this section, I explore how traditional beliefs and religious frameworks shape perceptions of mental health within South Asian communities. The focus is on examining how cultural concepts of shame (*sharam* in Hindi) and honor (*izzat* in Hindi) contribute to stigma, as well as the role of spiritual practices like Ayurveda, a traditional Indian system of medicine that incorporates herbal remedies, meditation, and yoga, and

[23] Lindsey Phillips, "A Closer Look at the Mental Health Provider Shortage," May 2023, https://www.counseling.org/.

[24] Goon and Chapman-Novakofski, "Call for Cultural and Language-Concordant Diabetes Care, Nutrition Education, and Self-Management for South Asian Individuals Living in the US."

[25] Ibid.

Pentecostal theology, which emphasizes faith healing, prayer, and spiritual deliverance, can both aid in addressing mental health care by providing holistic support or complicate it by discouraging medical interventions in favor of solely spiritual approaches. These cultural and theological influences significantly impact mental health awareness and care-seeking behaviors.

Historical Beliefs in the South Asian Diaspora

South Asian communities are steeped in a cultural framework where mental health is often misunderstood and stigmatized. Perception of shame (*sharam*) and honor (*izzat*) profoundly influenced attitudes toward mental health under the neoliberal period. Psychological disorders are often considered the manifestation of personal or family weaknesses, and people try to hide their problems to avoid shame for their lineage. For example, diseases such as depression or anxiety are regarded as diseases that are due to a lack of willpower and can be easily overcome by willpower. These cultural perceptions make people shy away from seeking help, thus allowing mental health issues to remain unaddressed. Misconceptions about mental health within the South Asian diaspora also stem from a lack of education and awareness. It is well established that in many conventional South Asian societies, mental illness is commonly viewed because of fate, a curse, or being possessed by black magic. This belief replaces rationality with rituals or spiritual cures, preventing the user from seeking professional help.[26] For example,

[26] Mrugesh Vaishnav et al., "Stigma towards Mental Illness in Asian Nations and Low-And-Middle-Income Countries, and Comparison with High-Income Countries: A Literature Review and Practice Implications," *Indian Journal of Psychiatry* 65, no. 10 (October 1, 2023): 995.

families might seek psychological problems to be solved by astrologers or spiritual healers, as they think it is moral to do so. Such beliefs can hinder the adoption of effective therapies, medication, and other treatments for acknowledged psychological disorders.

In addition, more modern practices, such as Ayurveda and spiritual healing, are also incorporated into how the South Asian community addresses mental health. This is responsible for utilizing holistic medical practices from the South Asian subcontinent. Although Ayurveda has many treatments for everyday health, its treatments for psychiatric disorders may be restricted to herbal medications or purification measures that do not treat the actual mental illness. Prayer and meditation are also an integral part of spiritual healing tactics. As such, despite the psycho-emotional impact, many of these practices are perceived not as adjuncts but as substitutes to clinical care and are often left untapped when they can add value to the primary treatment.

Pentecostal Theology and Mental Health

Faith, prayer, divine healing, and spiritual warfare are central to Pentecostal theology, significantly shaping how South Asian churches understand and approach mental health. Pentecostalism affirms the immanence of the Holy Spirit in daily life, emphasizing miraculous healing for physical, emotional, and mental afflictions. Divine healing is often viewed as the primary solution to all forms of suffering, including mental illness, which can lead congregants to prioritize prayer and deliverance over medical or

psychological interventions.[27] This theological framework usually assumes a religious approach to tackling problems of life, such as mental illness.[28] While faith-based interventions can provide significant comfort and hope, an overreliance on these practices can unintentionally marginalize psychological and medical approaches to mental health care. The Pentecostal church's cultural belief in Divine healing often results in a congregation perceiving mental ailments as only a spiritual issue. For instance, anxiety or depression can be seen as a sign of weak faith, satanic influence, or unconfessed sin. Members of the religious group may be asked to pray or seek deliverance instead of going to therapy or taking medication.[29] While prayer and spiritual deliverance are meaningful aspects of faith, relying solely on these methods can delay necessary interventions, exacerbate mental health conditions, and lead to prolonged suffering, increased stigma, and a lack of access to professional care.

Furthermore, Pentecostal theology has a very low tolerance for sin, stress, and disease and encourages battling them in a spiritual realm so that those who are struggling or are weak are often silenced. Ironically, citizens in the congregation may develop stress to hide the challenges of mental health issues from friends, family, and church members through Christ's victory because they think that they are incompetent to conquer

[27] Rose Jin et al., "Mental Health Stigma Across Cultures: A Comparative Study," *International Journal of Mental Health* 29, no. 4 (2022): 345-360.

[28] Pamela D. Trice and Jeffrey P. Bjorck, "Pentecostal Perspectives on Causes and Cures of Depression," *Professional Psychology: Research and Practice* 37, no. 3 (2006): 283–94.

[29] Ibid.

adversities by faith.[30] This cultural silence within the church creates an additional layer of stigma, preventing individuals from seeking help.

However, Pentecostal theology has some advantages for promoting mental health support. For example, Pentecostal worship emphasizes people being together, increasing the sense of community. Mental health patients often admit that worshipping and testifying freely with others minimizes the feeling of loneliness through shared experiences.[31] Pentecostal views of hope and the divine plan offer hopeful terminology that can serve as avenues to help people cope with ordeals. Incorporating these theological strengths into the best practices in mental health treatment results in an encompassing solution.

Religious Practices and Their Implications

Religious practices within South Asian Pentecostal churches significantly shape congregational attitudes toward mental health. Weekly gatherings, sermons, and communal rituals are central to the church's life, serving as opportunities for spiritual growth and community engagement. However, pastors are often approached to resolve cultural conflicts beyond theological concerns. These conflicts may involve differing expectations around freedom, vacation, child-rearing philosophies, and disciplinary practices, particularly between first-generation immigrants and their more acculturated children. Differences in parental expectations, autonomy, and traditional versus modern

[30] Samuel Stroope et al., "'Mental Health and Self-Rated Health among U.S. South Asians: The Role of Religious Group Involvement,'" *Ethnicity & Health* 27, no. 2 (August 30, 2019): 1–19.

[31] Trice and Bjorck, "Pentecostal Perspectives on Causes and Cures of Depression," 283-94.

disciplinary methods can create family tensions, which pastors are expected to navigate despite limited literature addressing these specific challenges. The lack of theological and psychological resources for addressing these issues leaves church leaders unprepared to mediate such disputes effectively, further complicating pastoral care responsibilities within South Asian congregations.[32]

Sermons frequently emphasize themes of spiritual warfare, where struggles are attributed to external spiritual forces rather than psychological or physiological factors. While this perspective aligns with Pentecostal theology, it can perpetuate harmful beliefs about mental illness. For example, congregants with depression or anxiety may be led to believe that their condition is caused by demonic oppression or a failure to live a righteous life.[33] Such narratives not only stigmatize mental health struggles but also discourage individuals from seeking professional help, as they may feel that their issues require only spiritual solutions. Prayer meetings and deliverance sessions also shape the way people handle cases of mental illness. Though such practices offer consolation and encouragement, they are typically oriented only to spiritual means. For example, a congregant who has post-traumatic stress disorder would attend a prayer meeting to pray for deliverance from fear. Yet, in the absence of psychological therapies, the core issues of their anxiety may never be resolved. Unfortunately, such overemphasis can create frustration and nurture spiritual practices as the long-lasting solution when such

[32] Stroope et al., "'Mental Health and Self-Rated Health among U.S. South Asians," 1–19.

[33] Ibid.

symptoms do not resolve, thus making the person feel spiritually exhausted and, at times, sinful (or shameful).

Theological misconceptions about mental health challenges further exacerbate these issues. Any form of mental illness is still viewed as a lack of moral character or even a lack of faith, which precludes any healthy dialogue within the church setting. The members of a congregation may feel stigmatized if they openly speak about their mental problems, and therefore, mental illness becomes invisible.[34] This isolation even applies to families since they still want to uphold a precarious image in the church if one of their own is mentally unwell.

However, religious practices also have a possibility of having positive effects. This way, there is education and awareness, which can be reinforced by pastors and church leaders when presenting the balanced view. To prevent stigmatization and mental health promotion, pastors can teach about resilience and self-care and include faith and therapy in sermons, which can change the congregation's attitude.[35] Testimonies from individuals who have sought professional help alongside spiritual practices can also encourage others to do the same, reducing stigma and fostering acceptance.

Organizational Structure and Practices

In this section, I examine leadership models, training practices, and gaps within South Asian churches in North America. I explore the hierarchical governance structure

[34] Jean Neely, "How the Church's Approach to Mental Illness Can Shame the Suffering," *Sojourners*, March 28, 2018.

[35] Stroope et al., "Mental Health and Self-Rated Health among U.S. South Asians," 1–19.

that shapes decision-making and pastoral care, how the lack of mental health training in pastoral education is highlighted, and how these factors affect the church's ability to effectively address mental health needs.

Structure of South Asian Churches

Leadership style in South Asian churches in North America may be influenced by the cultural and theological orientation of where church leaders originate. A system of governance in leadership adopted by most churches is autocratic because organizational power is vested in pastors and other senior leaders. The hierarchical structure is shaped by cultural values that prescribe high degrees of respect towards elders and other people of authority.

In SA contexts, the clergy are understood as people occupying a religious function and possessing decision-making authority of a godly nature.[36] Elders are generally chosen because of their age, experience, and spiritual age; they stay as assistants and help pastors make decisions regarding the congregation. Lay leaders, including deacons, ministry heads, and volunteers, support the church's operations. They are usually in charge of sections of the church, such as youth, women, or Sunday school. The fact remains that most lay leaders have civil roles, though they play key roles in the functioning of the church. However, most of the decisions are made by the pastors and elders. This structure provides the hierarchy of command and supervision but does not

[36] Kent et al., "Religion and Spirituality among American Indian, South Asian, Black, Hispanic/Latina, and White Women in the Study on Stress, Spirituality, and Health," 198–215.

encourage creativity or a teamwork problem-solving approach to inherent multifaceted problems such as mental health.[37]

A shared leadership model has begun to take root in some South Asian churches, especially among younger and second-generation immigrants. They engage in task interdependence with pastors, elders, and other lay members to meet the congregation's needs. This approach fosters greater inclusivity and encourages members to participate actively in church initiatives. Nevertheless, patriarchal systems, as an additional layer within the hierarchical power structures previously discussed, remain the most prevalent in South Asian churches. These systems not only diminish the potential for appropriate and creative engagement with new issues like mental health but also further silence women, limiting their ability to advocate for mental health awareness and access to care within these religious communities.

Current Pastoral Training Practices

Potential pastors and existing leaders in the South Asian church ministries receive their training in theological education, spiritual direction, and missional church. In many South Asian church ministries, ordination is required for pastors and leaders, typically involving theological education, spiritual formation, practical ministry experience, and approval by church authorities or denominations.[38] In seminaries and Bible colleges,

[37] Alexandria Springfield and Virginia Yera Keita, "ScholarWorks Leadership Styles and Their Impact on Church Growth In," 2019, https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=8437&context=dissertations.

[38] Andrew Thomas Hancock, "Pastoral training approaches in the local church: A multi-case study" (2018).

biblical interpretation and analysis of sermons and counseling are argued to be fundamental courses.[39] In pastoral training, courses emphasize teaching leaders to thoroughly understand the Bible and training how to lead a congregation properly. Moreover, training can cover topics such as Word and power, church administration, conflict solving, and community work, typical of pastors' activities.[40] While these focus areas are essential, education on mental health in most pastoral training programs is missing. Very few seminarians are ever taught how and where to identify, understand, or intervene with mental health issues in their congregations. For example, training programs usually do not include the symptoms of anxiety and depression, the effects of trauma, or referral to professional mental health services.[41] Many pastors do not receive adequate training in psychology before entering into pastoral ministry, which would have helped them address the needs of their congregation; instead, they are limited to praying and providing spiritual counseling as the only solution.

In addition, cultural and theological biases significantly influence the training provided to pastoral workers. Mental health education is often treated as optional compared to the emphasis on addressing spiritual crises or evangelistic priorities. This perspective may lead pastors to undervalue mental health resources or avoid

[39] Lloyd Solomons, Gift Mtukwa, and Marilyn Naidoo, "Negotiating Tradition and Change in Pastoral Training in the Church of the Nazarene in Africa," *HTS Teologiese Studies / Theological Studies* 80, no. 1.

[40] Springfield and Keita, "ScholarWorks Leadership Styles and Their Impact on Church Growth In."

[41] Solomons, Mtukwa, and Naidoo, "Negotiating Tradition and Change in Pastoral Training in the Church of the Nazarene in Africa."

collaborating with professionals outside the church community.[42] In this way, the pastoral leaders might continue these beliefs about mental health and leave those suffering to themselves. Initiatives to teach about mental health in the pastoral formation process remain nascent in most South Asian church settings. However, some younger institutions and organizations are starting to realize the need to educate pastors on how to handle cases of mental health. While these programs remain relatively small-scale, their work speaks volumes to redirected expectations of South Asian churches on issues regarding mental health.

Gaps in Mental Health Training

The absence of any specific mental health input as part of pastoral training raises significant questions about the readiness of South Asian churches and their congregations to meet this need. It is common to find pastors or leaders with no training in mental health issues failing to notice a person in distress or know how to respond.[43] For example, a congregant with severe depression is counseled to pray, read the Bible, and go to church prayers, among other recommendations, without being referred to a psychiatrist or therapist. Support received through spirituality can be helpful, but it does not address the technicalities of mental health disorders. Asians and Asian Americans have the lowest rate of mental health service utilization (25%) in the US compared to other racial/ethnic groups (39% − 52%) despite high rates of depression, anxiety, and suicidal ideation. The

[42] Ibid.

[43] Anthony David Campbell, "Clergy Perceptions of Mental Illness and Confronting Stigma in Congregations," *Religions* 12, no. 12 (December 17, 2021): 1110.

lack of culturally relevant and competent mental health training hinders access to mental health services for these populations.[44] New-generation leaders with a more progressive view towards mental health but without adequate training can also contribute to the stigma regarding such mental health issues, believing that these issues result from a failure to have faith or be spiritually strong. This approach not only isolates individuals but also discourages them from seeking help. This fuels the stigma and shame the South Asian church attributes to mental illnesses. Church members, if they are feeling judged or misunderstood by their pastors, may feel compelled to opt out of the church, potentially leading to increased feelings of isolation and hopelessness.

The lack of mental health training also explains why the church is unable to offer all-round care that includes spiritual, emotional, and psychological domains. The clergy is directly involved in the daily lives of church members and acts in an early intervention role when a member is distressed. Pastors might overlook underlying chances for intercession, encouragement, and referrals to the right services if they lack adequate training.[45] Meeting the gaps identified above means offering mental health education as part of pastoral training should be intentional. Training on issues such as teaching congregants about signs of mental illness, theological and cultural aspects of stigma, as well as fostering and developing teamwork with mental health care specialists, must

[44] Min Kyung Kim et al., "Mental Health Priorities and Cultural-Responsiveness of the Mental Health First Aid (MHFA) Training for Asian Immigrant Populations in Greater Boston, Massachusetts," *BMC Psychiatry* 24, no. 1 (July 16, 2024).

[45] Krissie Glass, "Mental Health and the Church," June 10, 2020, https://www.careforpastors.org/mental-health-and-the-church.

occur. Also, pastors require tangible resources, especially a referral base of specialists in the mental health field who can provide mental health care and guidance.

South Asian churches also need to foster a culture that integrates mental health as a significant aspect of the church's ministry. This involves educating the congregation on emotional well-being, normalizing conversations about mental health to affirm that it is acceptable to experience struggles and challenging discriminatory attitudes toward mental health care.[46] It also requires eliminating the stigma and profiling of congregants with mental health concerns, ensuring that everyone feels supported and encouraged to seek help within the church community. With proper knowledge and skills, pastors and leaders in churches can help reduce the stigma around mental health and enhance the well-being of those struggling with mental health issues.

Impact of Stigma on Mental Health

In this section, I explore the stigma within South Asian communities hindering help-seeking behaviors and exacerbating mental health issues. The cultural perceptions of mental illness, pastoral responses, and the harmful consequences of neglecting professional care are highlighted, along with the critical need for mental health education and the reduction of stigma within church settings through case studies and anecdotal evidence.

[46] Zhisong Zhang et al., "Overview of Stigma against Psychiatric Illnesses and Advancements of Anti-Stigma Activities in Six Asian Societies," *International Journal of Environmental Research and Public Health* 17, no. 1 (December 31, 2019): 280.

How Stigma Affects Help-Seeking Behavior

Perceived stigma has been cited as the most devastating factor affecting the treatment of mental health disorders among South Asian populations.[47] The strong cultural belief common in concepts of *izzat* and *sharam* impacts how families and individuals within the community perceive mental health disorders. Mental illness is often seen as a personal weakness or a symptom of a bad upbringing, which results in fear of rejection. The latter builds strong resistance to seeking help because one does not want to be considered by others to be weak or crazy.

In South Asian churches, this hesitation is further compounded because people are afraid that they lack faith or are unfaithful. Instead of consulting a qualified psychological specialist, a church member turns to individual ways of dealing with a mental health issue such as repression, denial, or withdrawal. Often, these strategies provide only temporary and unhealthy solutions and worsen the situation. Those who become incapacitated seek religious solutions, invoking prayer, fasting, or some form of meditation. These practices can help obtain comfort and a sense of companionship in some situations; however, they do not replace the positive effects of clinical help in the presence of severe anxiety, depression, or trauma. The seemingly limitless preference for spiritual remedies for mental health over conventional professional treatment stems from a profound and

[47] Li Ping Su-Kubricht, Hao-Min Chen, Shuiyan Guo, and Richard B Miller, "Towards Culturally Sensitive Care: Cultural Views and Mental Health Stigma in South Asian Populations," *Contemporary Family Therapy*, September 6, 2024.

justified skepticism regarding mental health services, considering the absence or scarcity of culturally appropriate services in North America.[48]

In addition, stigma is a key factor in how families respond to mental health issues. It is common for families to discourage individuals from seeking professional help to avoid gossip or negative judgment from church members. This collective denial prevents meaningful discussions and perpetuates isolation for those suffering. Without recognition and encouragement, individuals may delay treatment until their condition significantly worsens.

Pastoral Response to Mental Health Issues

Ministry leaders such as pastors and elders are usually the first people that individuals and families with mental health issues turn to for help. Generally, in South Asian churches, ministry tends to work through prayer, advising, or deliverance. These stem from a theological worldview that believes faith and divine intercession can reconcile all human suffering, including mental ailments. While such practices help people find spiritual comfort and motivation, they are not always sufficient to meet a person's psychological and clinical requirements.

Prayer is the most common pastoral response to mental health concerns. It is not new to hear pastors call their congregants to pray for strength, direction, or a miracle. As shown previously, prayer can be highly effective as an emotional support technique in

[48] Michelle Kermode et al., "Community Beliefs About Causes and Risks for Mental Disorders: A Mental Health Literacy Survey in a Rural Area of Maharashtra, India," *International Journal of Social Psychiatry* 56, no. 6 (2010): 606-622.

response to mental health cases; however, this also proves highly problematic if that is all the pastoral leader offers. For instance, a congregant suffering from prolonged severe depression is taken through prayer without the clergy encouraging them to see a doctor. This strategy not only entices people to avoid seeking treatment but also results in guilt or spiritual incomprehension of the sick to remain sick.

Counseling is another common pastoral intervention. Most pastors have personal consultation meetings where they comfort members of the congregation. However, it is essential to note that most of the leaders in the pastoral contexts receive little or no training in mental health counseling, meaning that they can scarcely decipher deeper psychological conditions.[49] They may advise one to downplay symptoms or even give one a belief about mental health that is incorrect. Moreover, the congregants might be reluctant to disclose their problems due to the stigma or violation of mandatory confidentiality rules within churches. Some churches in South Asia, particularly Pentecostal, use exorcism, or what they call spiritual deliverance, for people with mental health issues since the group considers these issues as spiritual attacks or spiritual battles. Other activities like prayer sessions, fasting, and performing specific rites are also done in deliverance sessions.

These practices align with Pentecostal theologies but rarely consider the biological and psychological aspects of mental health. Hence, if someone is not cured right away, they may feel as if they are alone and that no one wants to help them get better, which only worsens their seclusion and desperation. These limitations indicate that

[49] Gary L. Kreps and Lisa Sparks, "Meeting the Health Literacy Needs of Immigrant Populations," *Patient Education and Counseling* 71 (2008): 328-332.

more must be done to provide mental health education within church leadership. Religious institutions can close this gap and ensure pastors have the knowledge and resources to deliver psychological interventions.

Case Studies and Anecdotal Evidence

The harmful impact of stigma and inadequate church responses is evident in numerous case studies and personal accounts from South Asian congregants. One such case is when a young woman was suffering from postpartum depression. Even though she displayed many symptoms of her depression, including isolation and fatigue, her husband and parents ridiculed her, saying it was just a phase of motherhood. She shared her story with her pastor, who advised her to pray and believe God was in charge. The woman soon developed a serious postpartum medical issue requiring hospital re-admission. In this case, stigma and lack of proper care worsened her physical and mental health, leading to a critical issue for her and her child.[50]

Another example is that of a middle-aged man who developed severe anxiety, leading to job loss. Seeing it as a spiritual problem, his pastor arranged for him to receive prayer and deliverance services. Although these can offer temporary solutions to soothe the individual, they cannot solve the root cause of his anxiety. In the man's case, he decided to engage in therapy to cope with his life and become steady again. His

[50] Saba Mughal et al., "Postpartum Depression," *National Library of Medicine* (Treasure Island, FL, StatPearls Publishing, 2024), https://www.ncbi.nlm.nih.gov/books/NBK519070/.

experience highlights an increased chance for positive results if professional mental health care works with pastoral care.

On the other hand, positive examples show how trained pastoral leaders can bring these changes about; for instance, in one local church, a pastor who has received education on mental disorders was able to identify symptoms of depression in young members. The pastor offered counselling while recommending the person to a culturally relevant therapist. This dual-centred approach was beneficial for the congregant and motivated other church members to seek help regarding their mental health issues.[51] These case studies show how pastors are strategically positioned to influence the attitude and fate of the congregation. With the proper training, pastors can decrease prejudices, enable conversations about mental health issues, and direct congregants to professional help.

Challenge for Pastoral Care

In this section, I examine the gaps in South Asian churches' ability to address mental health concerns due to inadequate pastoral training and cultural barriers. How current spiritual approaches, while offering comfort, often neglect the psychological aspects of mental health are highlighted while underscoring the importance of equipping pastors with knowledge and resources to provide comprehensive care for mental health issues.

[51] Anthony David Campbell, "Clergy Perceptions of Mental Illness and Confronting Stigma in Congregations," *Religions* 12, no. 12 (December 17, 2021): 1110, https://doi.org/10.3390/rel12121110.

Inadequacies of Current Pastoral Approaches

Pastoral care in South Asian churches often falls short when addressing mental health challenges due to a lack of training and awareness among church leaders. While most pastors are well-grounded in theological education and spirituality, few are trained to identify or manage psychological conditions. This gap keeps them unprepared for the issues around mental health disorders such as depression, anxiety, or trauma. For example, should someone socializing at a particular church or temple develop signs of severe mental distress, that person is considered to be spiritually troubled, not physically ill. This misinterpretation prohibits relevant interventions for the person and lengthens their suffering time.

This problem is aggravated by the fact that South Asians with mental health issues rely mostly on theological or spiritual approaches as the primary way of seeking help. This includes prayer, fasting, or, in extreme cases, explicit deliverance, all of which Pentecostals employ since they believe in Divine intervention. Despite these practices helping people find comfort and meaning in the situation by providing an emotional and spiritual framework, these frameworks usually eliminate aspects of a person's body and mental condition. In one instance, the individual may be suffering from clinical depression; they are encouraged to pray more or put their faith in the divine power to heal them without immediate referral to see a therapist or take medication. This can paradoxically worsen feelings of guilt or inadequacy if symptoms persist, solely isolating such individuals. Also, it is crucial to note how members of South Asian origin react towards mental health and how pastoral care reinforces the notion that the disease is a result of a lack of faith and spiritual strength. This attitude discourages open conversation

and makes shame persistent, making it extremely difficult for a person to seek help. Without the pastors knowing it, they perpetuate the stigma around mental health, isolating individuals who need help. These imperatives also underline the requirement of a far richer model of pastoral care to advance theological reflection and psychological knowledge.

Linking Challenges to the Project's Purpose

The problems stated above speak volumes about why this doctoral project is essential. Empowering South Asian pastors and church leaders to develop appropriate ways of handling mental health concerns is the project's ultimate goal. Due to the pursuit of knowledge, minimization of prejudice, and organization of the mental health-promoting environment, in this project, I aim to enhance the pastoral care role in South Asian churches. There is little training available among pastors on mental health issues, which co-relates with my aim of creating awareness. Requiring pastors to take courses in mental health will increase their ability to identify mental disorders and appropriately intervene. Making specific mental health workshops, seminars, and resource materials that are culturally and theologically sensitive to the South Asian context available to pastors is critical for them to become champions for mental health.

Another goal of this project is to reduce the stigma around mental illness and mental health, enabling congregants to discuss their mental health and openly access help. While it may require undoing toxic cultural beliefs and practices, pastors and leaders raising people's consciousness about the importance of good mental health can potentially build churches willing to embrace these changes. This means ensuring leaders

and all congregation members are prepared to have a positive attitude towards mental health. For instance, preachers can include mental health in their preaching or organize discussions where people are encouraged to seek help.

Through this project, I aim to cultivate a mentally healthy environment in South Asian churches in North America, enhancing spiritual support, which is strongly linked to the psychological support prevalent in today's congregation. This entails educating pastors and clergy to work with psychiatrists, psychologists, and social workers, creating therapeutic pastoral care groups within churches, and creating links to other professionals. Having openly addressed spiritual and psychological concerns, South Asian churches can become places where individuals feel safe to receive help.

Conclusion

In this chapter, I dissected the major features concerning mental health within South Asian communities in North America into demographic factors, cultural and religious influences, structures of institutions, and stigma. Mental health issues in these communities are often dismissed or overlooked as they grapple with cultural expectations, distorted religious beliefs, and inadequate preparation and resources among the clergy. Demographics revealed that South Asian patient populations are diverse and quickly growing. In contrast, the cultural and religious sections showed that stigma affects information-seeking behaviors. Furthermore, some South Asian churches do not have the structural capacity or training required to handle mental health problems and, consequently, turn mostly to prayer and worship rather than utilizing more psychological resources.

These issues need a culturally responsive pastoral care and mental health education framework. I hope to create positive change through this project by providing church leaders with tools and information to identify and address mental health issues. These recommendations, as well as providing theology schools with more mental health-focused education, will lessen the stigma attached to mental illnesses and keep discussions on this topic going in congregations. In this chapter, I built the context for the following literature review, where academic insights on mental health, the church's position, and best practices in addressing stigma and promoting healthy living are presented. In the next chapter, I establish through the literature review a framework for theological, cultural, and practical considerations of contextual mental health care within South Asian churches.

Part Two

Theological Reflection

Chapter 2

Literature Review

In this chapter, I explore the key topics relevant to integrating mental health care and destigmatization efforts in South Asian congregations. I examine scholarly contributions, evaluating their strengths and weaknesses and highlighting gaps that inform the objectives of this project.

Cultural Norms and Stigma in Mental Health

Traditional beliefs and practices shape the culturally prescribed expectations of mental disorders within the South Asian population. They are essential in developing cultural perceptions of mental health and heavily influence help-seeking behaviors.[1] Li Ping Su-Kubricht et al.[2] present the rationale that a bounded cultural view of South Asian society based on collectivism and emphasizing familial and social cohesion also contributes significantly to the stigmatization of mental health. Mental health as an affliction or an individual challenge is not just a personal, private burden but also an embarrassment to the entire family in collectivist societies.[3] Therefore, it is considered taboo to accept that one has a mental illness or any disorder because it is regarded as a disgrace to familial honor; hence, many keep it to themselves. Thus, there are attempts to

[1] Karasz et al., "Mental Health and Stress Among South Asians," 7-14.

[2] Su-Kubricht et al., "Towards Culturally Sensitive Care."

[3] Ibid.

silence and deny, and mental health problems remain concealed, with professional help being rarely sought.[4]

Su-Kubricht et al.[5] also focus on social expectations as the reason for stigma sustainability. For instance, individuals are often expected to conform to societal norms that equate emotional stability with strength and resilience. This expectation prevents people from openly discussing their afflictions, serving to strengthen the belief that mental health issues signify failure.[6] However, such prejudices exist even when the overall global awareness of mental health issues is slowly growing; people of South Asian origin are still somewhat reluctant to seek professional help as it can be a sign of weakness or shameful behavior.

From this viewpoint, Su-Kubricht and Chen[7] further elucidate how gender roles, when combined with cultural attitudes, add layers to mental health stigma. They remark that women, for example, are hindered even more when it comes to accessing mental health help.[8] It has always been a norm for many women in South Asia to be considered as caregivers of their families and not the other way around.[9] When women find

[4] Li Ping Su-Kubricht and Hao-Min Chen, "Gender Roles and Mental Health Stigma in South Asian Communities," *Gender and Society* 38, no. 1 (2024): 75-90.

[5] Ibid.

[6] Su-Kubricht, "Towards Culturally Sensitive Care."

[7] Su-Kubricht and Chen, "Gender Roles and Mental Health Stigma in South Asian Communities."

[8] Neha Mahapatra, "South Asian Women in the U.S. and their Experience of Domestic Violence," *Journal of Family Violence* 27, no. 5 (2012): 381-390.

[9] Lee Rennie, Yue Qian, and Cary Wu, "Coethnic Concentration and Asians' Perceived Discrimination across U.S. Counties during COVID-19," *Socius: Sociological Research for a Dynamic World* 8 (January 2022): 237802312211245.

themselves experiencing anxiety or depression, the conditions are often contradictory and described as mood swings or hormonal imbalances, not genuine medical conditions.[10] This gendered viewpoint not only understates the intensity of the two but also keeps women from seeking future treatment. According to Su-Kubricht and Chen, culturally appropriate solutions the church embraces must be employed to eliminate the biases in traditional gender models.[11]

In South Asian communities, mental health issues are often viewed through a lens of stigma, with cultural beliefs and attitudes significantly shaping how mental health problems are perceived. A study by Ling Jin et al. highlighted that mental health stigma varies across ethnic groups, emphasizing how these attitudes can influence the understanding and treatment of mental health within South Asian communities.[12] In most Western societies, where the benefits of individualism are prominent, self-actualization has a higher priority than an organization's image.[13] Mental health struggles are more openly discussed and addressed, with less fear of societal judgment. While stigma does exist in Western contexts, Jin et al. note that it lacks the same collectivist implications prominent in South Asian communities.[14] Jin et al. extend present scholarship by

[10] Tayyaba Rehman, "'Social Stigma, Cultural Constraints, They're Very Different': Health and Social Care in the Community," *Columbia Undergraduate Journal of South Asian Studies* 12, no. 5 (2020): 414-421.

[11] Su-Kubricht and Chen, "Gender Roles and Mental Health Stigma in South Asian Communities."

[12] Ling Jin et al., "Ethnic Cultural Value Typologies and Mental Health Parameters among Indians," *International Journal of Intercultural Relations* 86 (January 2022): 95–108.

[13] Ibid.

[14] Ibid.

featuring an overview of cultural norms like shame (*sharam*) and honor (*izzat*) among South Asians. *Sharam* refers to a deep sense of personal and collective shame, often tied to maintaining social respect and avoiding behaviors that could bring dishonor to the family or community. Conversely, *izzat* represents a person's honor and social standing, closely tied to family reputation and the community's perception. These concepts can significantly influence how mental health issues are perceived and addressed in South Asian cultures, as individuals may fear the loss of *izzat* or the shame (*sharam*) of disclosing personal struggles, leading to silence and reluctance in seeking help for mental health concerns.[15] In their study on Indian cultural values, they explain how these constructs regulate reactions toward mental health issues. For instance, a person who is suffering from depression might refuse treatment, believing that it will hamper the family image in society.[16] This is nothing close to the Western or even East Asian attitude where mental illness stigma exists but not with a sense of communal responsibility.

Cultural stigma also shows up as Su-Kubricht et al., Su-Kubricht and Chen, and Jin et al. researched mental health perceptions of people belonging to South Asian communities and revealed different aspects of cultural stigma. Cultural beliefs hinder mental health treatment as people fear being judged by their families. South Asians also feel compelled to suppress their suffering as society expects them to be strong, which furthers the perpetuation of stigmatized mental health conditions. The findings stress the need to address South Asian cultural factors to develop culturally relevant solutions based

[15] Ibid.

[16] Ibid.

on the barriers South Asians experience. Interventions to combat stigma should not violate these cultural values while at the same time helping South Asians gain a better understanding of mental illness.[17] For example, mental health promotion through engaging popular leaders like pastors and elderly congregants in churches can promote awareness concerning mental health by encouraging open discussions, providing education on mental health, and offering support through counseling or spiritual guidance. Leaders need to actively address mental health issues, challenge stigma, and create safe spaces where congregants feel comfortable seeking help. Bringing South Asian cultural language and stories into mental health programs, such as community workshops, awareness campaigns, or counseling initiatives, makes those programs more meaningful and acceptable by aligning with the community's cultural values, beliefs, and experiences.

The Role of the Church: Historical and Current Perspectives

Through its previous teachings, the church has played an essential role in society as an advocate for the mentally ill, as well as being a source of discrimination. According to Dein, religious institutions must be at the forefront of helping solve mental health issues among different cultures.[18] He points out that churches offer people, particularly those undergoing emotional challenges, spiritual direction and community support.[19]

[17] Jin et al., "Ethnic Cultural Value Typologies and Mental Health Parameters among Indians," 95-108.

[18] Dein, "Religious Healing and Mental Health," 657–65.

[19] Ibid.

Nevertheless, Dein also provides insights into the theologically informed erroneous beliefs that may be promoted in religious contexts, for instance, labeling mental health conditions as indications of spiritual weakness or sinfulness. These beliefs encourage people to abstain from seeking mental health services, leading to shame and isolation.[20]

In contrast, Curtis S. Lehmann et al. provide a positive view of the church and mental health, claiming that the church is the peacemaker that aims to comfort people with mental health issues.[21] Their cross-cultural qualitative study investigates how churches approach mental health hospitality in different contexts. Lehmann et al. find that while many churches strive to offer support, their responses often lack the nuance needed to effectively address complex psychological issues.[22] For example, in South Asian Pentecostal churches, prayer and spiritual deliverance are frequently emphasized as main resolutions. These theological considerations assume that spiritual treatments are sufficient but pay little attention to possible psychological and medical interventions. This, according to Lehmann et al., explains that reliance on spiritual solutions to mental health issues only aggravates stigma because it makes people believe that cognitive issues are simply spiritual challenges to overcome.[23]

Ellen Goodwin and Kathryn Kraft explain that churches extending efforts to include mental health education within the church ministry help create environments that

[20] Ibid.

[21] Lehmann et al., "Hospitality towards People with Mental Illness in the Church," 1–27.

[22] Ibid.

[23] Ibid.

allow church members to be open about their issues and seek help. As such, their study focused on churches that actively minimize stigma via education and talking about their programs, and their observations of transformation in congregational attitudes toward mental health were evident.[24] For instance, although opening up about mental health is now considered to be socially acceptable in specific settings when a pastor addresses it in church, the congregation gains a context, allowing them to accept their mental health problems without feeling stigmatized. Goodwin and Kraft concluded that since they are key local points of contact, churches can provide spiritual and mental health support and be a robust resource for helping the congregation.[25]

Additionally, Dein and Lehmann et al. argue that theological paradigms help churches view and respond to mental health issues; however, in the context of Pentecostalism in South Asia, faith and divine or supernatural liberation obscure correctly identifying mental health-related problems. This approach constrains how the church can respond to mental health issues while at the same time maintaining cultural prejudices that only view mental health as the lack of spirituality or faith. On the other hand, Goodwin and Kraft show that when churches stop perpetuating these myths, they can promote positive change by reducing the misconceptions people embrace.[26]

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[24] Ellen Goodwin and Kathryn Kraft, "Mental Health and Spiritual Well-Being in Humanitarian Crises: The Role of Faith Communities Providing Spiritual and Psychosocial Support during the COVID-19 Pandemic," *Journal of International Humanitarian Action* 7, no. 1.

[25] Ibid.

[26] Ibid.

Dein and Lehmann et al. emphasized the roles of the church from the broad perspective of culture and theology. Dein, on the same note, offers a more historical perspective regarding the revelation of churches regarding mental health issues. A cross-cultural perspective is brought by Lehmann et al., where the authors present that the provision of churches for people with mental disorders is not uniform. In contrast, Goodwin and Kraft provide helpful tips on how churches can demystify stigma and champion mental health by openly speaking about mental health issues.[27]

Nonetheless, these studies also show several research areas that should be investigated. Although systematic, Dein's work mainly discusses Western churches and does not elaborate on the features of churches in South Asia. Likewise, Lehmann et al. offer essential findings yet do not thoroughly explore the challenges of immigrant and diaspora churches, including how cultural and theological factors interact.[28] These gaps highlight the need for more research on how South Asian churches can effectively adapt their theological frameworks to support mental health initiatives.

Interventions and Best Practices: Educational Programs and Community Collaboration

Anti-stigma campaigns in churches seeking to fight for mental health, particularly children, may be focused on education and community participation. These approaches allow church leadership and the congregation to engage in active, informed discourse on

[27] Ibid.

[28] Lehmann et al., "Hospitality towards People with Mental Illness in the Church," 1-27.

mental health and help the members in need.[29] Toward this end, Birthe Fritz aims to assess the competencies of Protestant pastors, especially their readiness to deal with mental health problems among their congregants. Fritz had thorough, quantitative research substantiating how helpful workshops and training enhance pastors' mental health literacy.[30] Fritz states that prior studies have demonstrated that pastors who receive specific training are more willing and skilled at identifying mental health issues, providing initial support, and referring people to the right source.[31] Her findings demonstrate how educational approaches can enhance clergy competencies, facilitating a productive church climate that embodies pastoral ministry.

Gabriel Acevedo et al. focus on how pastorate or congregational support influences mental health. Their study highlights sermons concentrate on mental health issues and congregants' support groups as another essential factor of a supportive church environment.[32] Thus, according to Acevedo et al., congregations discussing mental health topics during sermons and structured group tasks have higher reported emotional well-being. Such activities are helpful to encourage people to start discussing and sometimes consult a professional when they experience mental health issues. The researchers reiterate the need to activate pastors and congregants to foster the culture of member care

[29] Birthe Fritz, "Pastoral Care and Mental Illness: a Quantitative Study to Explore the Competencies of Protestant Pastors in Germany to Support People Who Have a Mental Illness," *Spiritual Care* 13, no. 1 (September 15, 2023): 60–74.

[30] Ibid.

[31] Ibid.

[32] Gabriel A. Acevedo, Reed T. DeAngelis, Jordan Farrell, and Brandon Vaidyanathan, "Is It the Sermon or the Choir? Pastoral Support, Congregant Support, and Worshiper Mental Health," *Review of Religious Research*, September 2, 2022.

in the church.[33] They keep this model stigma-free so that regardless of a person's status, they will feel accepted by the religious leaders and other people.

In South Asian church contexts, the practical application of these best practices requires overcoming several contextual, cultural, and theological issues common in many South Asian congregations that adopt spiritual methods for resolving mental health issues, such as prayer and deliverance. Although these practices help to build spiritual resourcefulness, they cannot manage mental health issues. Although these practices help to develop spiritual resourcefulness, they cannot manage or alleviate major mental health issues completely. Combining theological perspectives in a training curriculum with psychological training is the proper approach to addressing this missing link.

According to Fritz, training programs should be developed based on concerns about the corresponding target group's beliefs and values, which is especially essential for South Asian churches. For instance, teaching sessions for pastors and lay leaders could involve issues on mental health as a faith and spirituality issue to counter a culture that perceives mental health struggles as spiritual frailty.[34] Another important factor in church interventions in South Asian communities is the involvement of people in those communities in those interventions. Acevedo et al. argue for collaboration between leaders of churches and mental health practitioners to increase the church's ability to meet diverse psychological needs.[35] These offer people opportunities to consult with

[33] Acevedo et al., "Is It the Sermon or the Choir?"

[34] Fritz, "Pastoral Care and Mental Illness," 60-74.

[35] Acevedo et al., "Is It the Sermon or the Choir?"

professionals while keeping the church at the center of supporting congregants' spiritual and emotional needs.

Addressing and incorporating educational programs and community partners into South Asian churches must consider culture. For example, the language, terminologies, and other aspects of health education should be in harmony with the cultural and theological backgrounds of the congregation. Similarly, Fritz notes that modifications in choice, design, and delivery of training material should also consider the language and culture of the target population. In future work, cultural adaptations of mental health concepts will be used to make a discussion concerning it broader and more tolerant, which could involve the South Asian church using metaphors or parables from scriptures.[36] The use of guest speakers and other individuals who have addressed mental health issues and proven that no one is exempted from these challenges will go a long way in ensuring that people embrace and get comfortable with the idea of seeking help.

Another strategic approach incorporates the adoption and operations concerning congregant-led programs, taking advantage of the fact that South Asian churches are communal. According to Acevedo et al., support groups have effectively created community and commonality in addressing mental health issues. For example, in South Asian churches, these groups could form part of existing church ministry programs like women's fellowships and youth or prayer meetings, where mental health is discussed and introduced from an already known and accepted foundation.[37] These initiatives could be

[36] Fritz, "Pastoral Care and Mental Illness," 60-74.

[37] Acevedo et al., "Is It the Sermon or the Choir?"

driven by the church, where lay leaders and congregants are involved in activities that support pastoral efforts to reach a broader base.

However, it can be argued that pastors have a central role in successfully implementing these interventions. Fritz underlines that pastors willing to share their own experiences of mental health challenges create a lasting impact on people's attitudes in the church. For instance, Sunday sermons that focus on mental health issues, supported by the text and theology of Christianity, could go a long way in eradicating the stigma surrounding mental health.[38] Acevedo et al. added that those pastors who engage with congregants in groups or workshops affirm and support the church as a compassionate and welcoming care system. Therefore, school-based educational programs and community partnership strategies can effectively reduce resistance and encourage the church's adoption of mental health initiatives.

The focus of Fritz's and Acevedo et al.'s studies can encourage pastors and congregants to be prepared with knowledge and skills in handling mental health issues. When carrying out such interventions in South Asian churches, there is a need to act while considering those churches' cultural and theological frameworks.[39] For this reason, spiritual care, coupled with an introduction of psychological education and collaboration with counselors of South Asian origin within churches, can enable congregants to have a safe place to address all their needs.

[38] Fritz, "Pastoral Care and Mental Illness," 60-74.

[39] Acevedo et al., "Is It the Sermon or the Choir?"

Gaps in Literature

The present and emerging literature on culture, theology, and mental health remains underdeveloped, especially concerning South Asian church communities. Such gaps indicate significant directions for future research and services to address culturally relevant and appropriate mental health policies in these populations.

First, significant research missing from the literature is a lack of understanding of the role of South Asian theological frameworks in shaping perceptions of mental health. Although extensive literature is available on religious beliefs and mental health in general theology and theological approaches to mental health (Dein; Lehmann et al.), literature examining South Asian religious perspectives is scarce. For instance, the resurgence of Pentecostal beliefs is typical in many South Asian churches, which advocate faith, prayer, and spiritual deliverance as the main strategies for handling human challenges. While these theological constructs provide rather considerable religious support, they can also cause misunderstandings of mental health. For example, conflating mental health issues with sin, sinfulness, faithlessness, or spiritual defeat. Exploratory studies analyzing how these theological beliefs inform stigma, help-seeking, and pastoral care among South Asian communities would help develop more suitable interventions for these congregations.

Second, there is a research gap relating to the lack of studies in the South Asian church contexts about how educational interventions can be applied in a church environment. Fritz and Acevedo et al. help people understand pastoral training programs and help them cope with mental health issues supported by the community. However, these studies are mainly in the Western world and do not consider the cultural and

theological differences found in South Asian congregations.[40] For instance, cultural expectations of South Asians originating from collectivistic cultures, compounded by family and religion, may be an obstacle, as individuals may worry about dishonor and family shame. Therefore, interventions that involve families and faith leaders within the South Asian region must be promoted and grounded to ensure cultural appropriateness and acceptability among the target population. Interventions for South Asian church settings must be informed by research focusing on the appropriateness of educational and collaboration-based strategies for South Asian churches.

Third, the role of younger generations in reshaping attitudes toward mental health within South Asian churches remains underexplored. Second-generation immigrants, on the one hand, are well-positioned to mediate between their first-generation parents' cultures and the overall culture of the countries they have immigrated to. Relatedly, this demographic group could be more willing to talk about mental health and seek professional assistance due to exposure to fewer negative perceptions regarding mental illness in school, media, and among peers. However, there is little evidence of how these younger congregants bring attitude changes within their respective churches. Knowing how second-generation immigrants and individuals of color approach mental health stigma could be beneficial in the attempt to bring change within the South Asian congregations.

Finally, while existing research addresses stigma and the church's role in mental health, there is a need for longitudinal studies that examine the long-term impact of

[40] Ibid.

interventions within South Asian churches in North America. Most research studies are limited to assessing changes within a short period after a particular workshop or sermon. However, prolonged analysis and awareness raising to change temporal cultural and theological perceptions are possible. Intervention studies might encourage knowledge of how to achieve changes in attitudes and resulting stigma and mental health care practices in the long term.

Conclusion and Relevance to the Project

In this chapter, I presented valuable literature reviews focused on understanding how cultural and theological factors influenced the uptake of positive mental health within South Asian churches in North America. Values influencing stigma and shame of cultural aspects, such as honor systems (Su-Kubricht et al.; Jin et al.), explain how stigma persists. Dein and Lehmann et al. pointed out that the church has posed challenges and opportunities for solving these problems because of its historical and communal function. Educational programs and collaborative interventions appear to be effective ways of combating stigma and preparing church leaders to deliver person-centered care. Nonetheless, as the identified gaps in the literature suggest, these strategies need to be nuanced for the South Asian immigrant congregation, given the strength of its cultural and theological background.

This project fills these gaps by designing a culturally appropriate approach to teaching about emotions as part of pastoral care. This scheme envisaged spreading the knowledge and acceptance of mental health issues to change the landscape by turning South Asian churches into the abode of spiritual and emotional well-being. The outlined

strategies for this project are built from the research findings of this literature review and point to a significant deficit in the literature on culturally appropriate interventions that link mental health care with pastoral ministry.

Chapter 3

Theology

In this chapter, I explore the critical relationship between theology and mental health. The main aim of this chapter is to provide a solid biblical and theological rationale as to why mental health is of crucial importance in the life of the church (especially in terms of South Asian Pentecostal churches in North America). I also give guidelines on how pastors and church leaders can react to mental health needs with a spiritually faithful and emotionally caring theology. Mental health is an emotional and medical concern as well as a spiritual one. When most individuals are affected by mental issues such as anxiety, depression, or trauma, they may turn to the church as a source of comfort. This makes the theology of utmost importance in how the church leaders and members can accept and interpret mental health. The conceptions that pastors have of God, suffering, healing, and the human person have a strong impact on how they treat people with mental health needs. When theology lines up as an effective tool, it can provide hope, care, and healing. But when it is misused, it can create shame, guilt, and silence.

Theology gives meaning to human experiences by helping individuals interpret suffering, recognize God's presence in the midst of hardship, and understand how faith can work alongside medical care. These are no mere hypothetical questions; they hit home to flesh and blood sitting in church pews every Sunday. That is why a healthy theology is required that accepts the strength of prayer and the significance of professional assistance.

I also illustrate in this chapter the connection between theology, psychology, and culture. Mental health care has been perceived as an independent issue and a matter of faith. Nevertheless, there are numerous aspects of mental wellness, including love, forgiveness, hope, and community, which are central to Christian theology. There can be convergence between good theology and good psychology. Meanwhile, culture influences individuals to consider mental illness in a certain way. There is a misunderstanding, or a veil of secrecy, regarding mental health in the South Asian communities as a result of shame or fear. Responses to mental disorders are more likely to be dictated by cultural values such as honor, family reputation, and spiritual purity than by Scripture. Thus, theology must include this issue of cultural patterns and present a kinder, more open, and Christ-like way of moving forward.

To guide this discussion, I identify and draw on the three major theological perspectives, which include Pentecostal/charismatic theology, pastoral theology, and liberation theology. Pentecostal/charismatic theology puts more focus on the active work of the Holy Spirit in the life of the believer, including a strong emphasis on divine healing, spiritual power, prayer, and deliverance. Although this theology provides profound spiritual hope and stresses the visible work of God in the healing process, it can often fail to address emotional and psychological aspects of human suffering. Pastoral theology focuses, in contrast, on the work of a pastor as a companion who walks among people in pain and provides support by presence, silence, and empathy. It emphasizes the spiritual assistance and the significance of emotional care, as the church leaders should not exclude the idea of healing based only on preaching. Liberation theology gives a justice-centered approach since it encourages the church to stand alongside the

marginalized, such as people with mental health challenges that are often ignored or blocked out. It asks the church to look beyond mental health as an individual concern and to envision it at the systemic and community level, which needs a collective voice and embraces shared responsibility for care. Collectively, these theologies establish a holistic foundation to help South Asian churches in North America approach mental health in a sacred, therapeutic, and dignified manner towards their congregation and society.

Biblical Foundations for Mental Health and Wholeness

In this section, I explore the biblical foundations that shape how I understand mental health and wholeness as essential to Christian life and pastoral care. Scripture provides profound wisdom on the value, dignity, and struggles of human life, offering a theological framework for addressing mental and emotional challenges. Both the Old and New Testaments emphasize God's concern for the whole person—body, mind, and spirit—demonstrating that mental health is not outside the scope of God's redemptive work. By drawing from Creation theology, the psalms of lament, prophetic calls to healing, and the ministry of Jesus, the Bible affirms the worth of those who struggle and calls the church to respond with compassion. This foundation is particularly vital for South Asian churches seeking to reduce stigma and offer holistic pastoral care.

Old Testament Perspectives

Creation theology addresses humans created in the image of God (*imago Dei*) found in Genesis 1:27. The foundation of human dignity and worth begins in Genesis 1:27, which declares that all people are created in God's image (*imago Dei*). This fact

certifies that all humans, no matter their mental or emotional condition, have value and deserve to be loved, attended to, and treated with respect.[1] With the South Asian community, mental illness is often a source of shame or stigma, and thus, this theological truth works well to remind South Asians that the mentally ill are not inferior in the sight of God. Being aware of the *imago Dei* forces the church not to isolate those in psychological suffering.[2] It also transforms pastoral caring, which was based on condemnation or a nonconfrontational attitude, to compassion and acceptance. In maintaining this primary assumption, churches can create a community that appreciates emotional wellness as a part of God's design towards wholeness.

The Psalms and the Book of Job offer profound insights into emotional and psychological suffering. Numerous psalms give voice to anxiety, despair, isolation, and grief, which are mental health issues linked to Psalm 42, which speaks of a soul cast down, yearning after God.[3] These words justify suffering in emotions and encourage people to take their problems to God. Likewise, the example of Job is that he was a righteous man who was undergoing severe suffering, including a loss of purpose and hope.[4] His friends provided facile answers, but it is God who glorifies in the lament Job makes and stands with him in his misery. These passages address the belief that suffering

[1] Lucy Peppiatt, *The Imago Dei: Humanity Made in the Image of God*(Eugene, OR: Wipf & Stock, 2022).

[2] Ibid.

[3] Rico Villanueva, *Lord, I'm Depressed: The Lament Psalms and Depression* (Manila, OMF Literature, 2019).

[4] Will Kynes, "Morality and mortality: The dialogical interpretation of Psalm 90 in the book of Job," *Journal for the Study of the Old Testament* 44, no. 4 (2020): 624-641.

can always be attributed to individual sin or the lack of faith, although elements of this belief can be detected in the religious environment of South Asia. Instead, they demonstrate that the journey of faith is associated with struggle and God embraces even humanity's loudest calls.

Isaiah 61 presents a powerful vision of God's concern for the emotionally wounded and socially marginalized.[5] The text refers to the mission of "healing the broken-hearted and comforting all who mourn," which alludes to healing the psychologically and emotionally wounded (Is 61). This is a prophetic word to the church, reminding the body of Christ of its mandate to bring healing, hope, and restoration to those who are physically, spiritually, and emotionally suffering. The stigma regarding mental health still exists in most South Asian churches. Isaiah shines through this silence and provides an example of ministry that is characterized by compassion, justice, and dignity.[6] This ambassadorship to comfort those with broken hearts and to support them calls on leaders and other congregants to develop communities that recognize emotional soundness as a key element of the redemptive work of God.

New Testament Perspectives

Jesus' ministry was intensely focused on healing the whole person, body, mind, and spirit. The incident of a man possessed by demons, found in Mark 5 and Luke 8, involves a man who is a loner living among the tombs and is absolutely possessed by

[5] Dominic S. Irudayaraj, *Violence, Otherness and Identity in Isaiah 63: 1-6: The Trampling One Coming from Edom* (UK: T & T, 2017), 1-224.

[6] Ibid.

demons. Jesus not only saves him from the spiritual oppression but also repairs his social identity, mental balance, and dignity. This narrative shows that the healing work of Jesus was not just restricted to physical healing but was also a comprehensive renewal of the emotional and mental state.[7] In South Asian churches, mental illness has typically been viewed purely as a spiritual/moral shortcoming, so this passage is essential in that Jesus was concerned with the suffering of the mind and its relation to holistic healing. His example speaks of the centrality of restoring mental and emotional health to the gospel message and lessons and provides a guide to pastoral healing that involves empathy and the presence of deliverance, all based upon love.

Throughout the gospels, Jesus consistently demonstrated compassion for those suffering from disease, emotional pain, or societal rejection. He cured the lepers, cheered the bereaved, and touched the outcasts of the community.[8] These restitution accounts underscore the fact that healing of body and mind is part of restitution in the kingdom of God. For instance, healing the woman with the issue of blood (Lk 8:43-48) shows Jesus acknowledging her fear, affirming her faith, and restoring her to the community. This paradigm of healing that is holistic and humane urges churches not to be dangerous places for those with mental illnesses. In the case of the South Asian congregations, these stories in the gospel help reiterate the fact that Jesus never stigmatizes nor does he shame; that he fully embraces the broken and completely heals them.

[7] Stephen Voorwinde, *Jesus' Emotions in the Fourth Gospel* (UK: T & T, 2005), 1-360.

[8] Willard M. Swartley, "The healing ministry of Jesus in the Gospels," *Vision: A Journal for Church and Theology* 22, no. 1 (2021).

In 2 Corinthians 12:9-10, Paul speaks candidly about his affliction, a "thorn in the flesh" which God did not remove despite his repeated prayers. In its place, God says, "My grace is enough to you, because my power is perfected in weakness." This text re-formulates suffering no longer as an indicator of faith-failure, but as an event in which the power of God can be seen. Those struggling with mental problems find great comfort in the words of Paul, who states that weakness does not exclude a person from God, or mean that they have lesser faith.[9] Paul's message that God's grace is sufficient and that weakness does not signify a lack of faith is essential in societies where mental disorders are highly stigmatized. The life of Paul reveals a lot: suffering is something that can exist together with faithfulness, and God works through one's brokenness.[10] It guides churches to develop empathy, resilience, and acceptance as aspects of their spiritual development.

Theological Anthropology

Theological anthropology teaches that humans are created as unified yet complex beings, embodying body, mind, and spirit. Such a holistic perspective acknowledges that mental health must never be isolated from physical or spiritual health.[11] In the South Asian culture, mental health is frequently neglected or considered as either a spiritual failing or an emotional weakness. A biblical view of the human individual or person

[9] Jason Scott Shawa, "The Necessity of Weaknesses in Experiencing the Grace of God: An Examination of Paul's Use of Grace, Culminating in 2 Corinthians 12: 7–10," PhD diss., Liberty University, 2024.

[10] Christopher M. Mahar, *Finding God in Suffering* (Alexandria, VA: Pauline Books and Media, 2023).

[11] Douglas Davies, *Anthropology and Theology* (Milton Park, UK: Routledge, 2020).

demands a coming together. Pastoral care must address a person's emotional and psychological dimensions, just as it addresses their spiritual needs.[12] This approach affirms that seeking therapy or medication is not contradictory to one's faith, but rather part of caring for the whole person. House churches that have this holistic perspective are in a better position to offer compassionate and practical care to people challenged by mental problems.

A common misconception, especially in some religious circles such as SA churches, is that illness, including mental illness, is a result of sin or personal failure. Scripture paints a more detailed picture, however. Although the Bible explains that sin has also affected all of Creation (Rom 8:22), it does not hold that every sickness originates as a result of individual sin. In Mathew 91:3, Jesus heals a man who was born blind and clarifies that his condition was not because of sin, but to work out the wonders of God. Such a view would be critical to South Asian churches, where mental illness can be talked about in terms of shame and blame. Understanding that suffering is an element of the human condition and it is not a punishment per se provides room for church communities to experience grace, empathy, and healing.[13]

The church has a decisive role in affirming the identity and dignity of every person, especially those struggling with mental health. In Christ, each believer is still made a part of a new crowd (2 Chr 5:17), a member of a single telephone number (1 Chr

[12] Samuel D. Ferguson, *The Spirit and Relational Anthropology in Paul,* vol. 520 (Tübingen, Germany: Mohr Siebeck, 2020).

[13] Hosseini Kohestani and Seyed Rasool "Investigating the Impact of Leaving Sin on Mental Health Care" *Journal of Gorgan University of Medical Sciences* 25 (2023): 7-13.

12:12-27), valuable and purposive. When the church echoes this in reality in its attitudes and ways, it becomes healing and a place of belonging. The church can be a place of recovery and inclusion for the South Asian communities whose mental illness can cause them either rejection or repression. Churches can dispel stigma by celebrating the identity of each member in Christ and their role in the body of Christ, creating a redemptive sense of wholeness.[14] Such a theological background gives freedom to pastors and leaders to discuss mental health not as an issue that should be taken away, but as a common human experience on the way to healing.

Pentecostal Theology and Mental Health

In this section, I explore how Pentecostal theology shapes the church's response to mental health through three main areas: key doctrines, faith and mental health, and the role of community and church. Pentecostalism emphasizes the power of the Holy Spirit through doctrines such as Spirit baptism, divine healing, and deliverance, which strongly influence how believers understand and address mental and emotional struggles. These beliefs impact how suffering is interpreted, whether as a test of faith, a call to prayer, or a battle with spiritual forces. At the same time, Pentecostal churches view the community of faith as central to healing, with pastors, elders, and Spirit-filled congregants supporting one another. This framework highlights both strengths and challenges in integrating faith and mental health care.

[14] Marinda Van Niekerk, "Dignity, justice and community as a baseline for re-interpreting being church in a Corona-defined world" *HTS Teologiese Studies/Theological Studies* 77, no. 4 (2021).

Key Doctrines

At the heart of Pentecostal theology is the belief in Spirit baptism, divine healing, and spiritual deliverance. Spirit baptism is considered an indication of salvation and empowerment within Christian living and the world, accompanied by spiritual gifts of speaking in tongues, prophecy, or healing. Pentecostal communities view healing as a special intervention by God, and through faith and prayer, the activity of the Holy Spirit can effect it.[15] Cyber-deliverance is sometimes believed to be the remedy to psychological or emotional ills, especially divine intervention to spiritual or demonic oppression. Although this belief system helps generate hope and faith in the capacity of God, it has helped to constrain the apprehension of mental illnesses as psychological and biological realities.[16] Through this, it presents a problem when believers tend to believe that psychological issues are always spiritual and can only be resolved through prayer or deliverance, and may neglect clinical or even therapeutic care.

In Pentecostal theology, the Holy Spirit is viewed as an active presence that brings comfort, renewal, and transformation to the lives of believers. Scriptures like Matthew 7:22-23 and John 14:26 talk about the Spirit as a comforter, assisting believers in their weakness. This means that there is immense hope for individuals who are found to be experiencing mental issues such as anxiety, depression, or even those who have been exposed to trauma.[17] It is thought that the spirit revitalizes an inner human being and

[15] Frank D. Macchia, "Spirit baptism and spiritual formation: A Pentecostal proposal," *Journal of Spiritual Formation and Soul Care* 13, no. 1 (2020): 44-61.

[16] Ibid.

[17] Tomy Kattampally, "The Role and Activity of the Holy Spirit in the Christian Life," *Dvkjournals.in*, 2025, https://dvkjournals.in/index.php/vs/article/download/3243/2965/6654.

imparts tranquility beyond comprehension (Phil 4:7). Pentecostals tend to derive satisfaction through intimate experiences with the Spirit in worship, prayer, and also at the communal gatherings. Pentecostal theology's emphasis on the active presence of the Holy Spirit is highly relational and experiential, creating a deeply supportive spiritual environment.[18] However, while the Spirit's role in comfort and healing is vital, it should be seen as complementary to professional mental health care rather than a substitute. It is possible to combine this comfort with psychological support to achieve comprehensive healing.

One of the significant tensions in Pentecostal theology is between belief in divine healing and the acceptance of medical or psychological treatment. Although most Pentecostals believe that God can also utilise doctors and therapists in the healing process, others interpret the use of medication or therapy as a weak faith. Some churches testify to the healing miracles, and some struggle or want mental health services, and they feel ashamed or feel looked down upon.[19] This is confusing and discouraging to those who are fighting mental illness, especially those whose condition does not change even when people pray over it. Among South Asian Pentecostal groups, where mental health is otherwise stigmatized, this conflict can be disastrous. One solution to bridging this gap can be done through the teaching of integration in the field of faith and science, whereby God is seen in the same way in both spiritual and medical treatments. Churches can

[18] Kwasi Atta-Agyapong, "Exploring the Idiosyncrasy of Pentecostal Distinctiveness in Engaging the Hearts and Minds of the Emerging Generation," *E-Journal of Humanities, Arts and Social Sciences* 5, no. 16 (December 24, 2024): 3021–31, https://doi.org/10.38159/ehass.202451627.

[19] Dein, "Religious Healing and Mental Health," 657–65.

accomplish this positively by advocating the moderate interpretation, and through prayer and professional assistance, these can be legitimate forms of faith and caring.

Faith and Mental Health

Pentecostal theology often interprets suffering within the framework of spiritual warfare. Whereas most Pentecostals agree that doctors and therapists are tools that God can use to cure people, some might believe that the use of medicine or counseling is a weakness of the person. Mental health testimonies in churches often focus on the miraculous healing that is celebrated over the testimonies of those who still struggle and seek mental help, and they are most likely to feel ashamed or judged.[20] This generates confusion and discouragement among individuals living with mental illness, particularly when practice fails to cure them even after they pray. This tension can be especially detrimental to the South Asian Pentecostal communities, as mental health is already the subject of stigma. Identification in the teaching of integrating faith and science and God's role in both spiritual and medical solutions aids in closing this gap.[21] The churches can support the balance of view and, in this way, support prayer and professional support as appropriate manifestations of faith and care.

In Pentecostal settings, there is a strong emphasis on miraculous healing. The instant conversion to deliverance of an addict, depression, or trauma is testified to during

[20] Simon Coleman, "Spiritual warfare in Pentecostalism: Metaphors and materialities," *The Wiley Blackwell companion to religion and materiality* (2020): 171-186.

[21] Tursinawati et al., "The Integration of the Nature of Science and Religion to Increase Students' Religious Beliefs in Acquiring Scientific Knowledge at the Elementary School," *Jurnal Prima Edukasia* 12, no. 1 (January 31, 2024): 140–55, https://doi.org/10.21831/jpe.v12i1.67649.

services. Concomitantly, testimonies can bring about all kinds of expectations; they may also lead to faith and hope. Not only is healing not always immediate and visible, but some people need lifelong assistance, therapy, and support to recover.[22] Recovery is mostly a long-lasting process involving relapses and slow progress in the improvement of mental health. This tension can stop individuals from turning toward long-term care in South Asian Pentecostal churches, where such help-seeking may be discouraged. It is necessary to understand how churches can work out their theology to appreciate both the miraculous interventions and the slower, supportive healing process. The belief that God operates through community, therapy, medicine, and time is an open judgment that builds an open space where individuals with diverse healing journeys feel welcome.[23] Ongoing pastoral care, small groups, and counseling processes are essential in shepherding people as they undergo their mental health processes.

A significant concern in Pentecostal theology is the tendency to spiritualize mental illness. Depression, anxiety, bipolar, and PTSD are at times only considered spiritually through the lens of demonic oppression, spiritual failure, or failure of faith.[24] This perspective can discriminate against people and prohibit them from seeking medical assistance. Over-spiritualization of mental illness might also cause feelings of guilt,

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[22] Samora Harry Ayivor, "Metamorphosis of Healing: Medicine, Divine Healing and Divine Health, the Place of Faith and the Word among African Pentecostals and Charismatics," *Transformation* 42, no. 2 (2025): 129-143.

[23] Brian J. Grim and Melissa E. Grim, "Belief, Behavior, and Belonging: How Faith Is Indispensable in Preventing and Recovering from Substance Abuse," *Journal of Religion and Health* 58, no. 5 (July 29, 2019): 1713–50, https://doi.org/10.1007/s10943-019-00876-w.

[24] Julie J. Exline, Kenneth I. Pargament, Joshua A. Wilt, and Valencia A. Harriott, "Mental illness, normal psychological processes, or attacks by the devil? Three lenses to frame demonic struggles in therapy," *Spirituality in Clinical Practice* 8, no. 3 (2021): 215.

shame, and confusion, particularly where the problem is unresolved even after the prayer or deliverance.[25] The theological misunderstanding adds to the silence existing in the South Asian community, where there is already a cultural taboo of mental illness. Churches should be careful not to refer to psychological disorders as simple spiritual problems. Although prayer and deliverance can aid, they are to be accompanied by understanding, education, and an appropriate referral. Educating congregants and leaders about identifying spiritual and psychological causes promotes a more humane and effective way to provide care, respecting the spiritual perceptions and expertise of professionals.

Community and the Church

Paul's vision of the church as the body of Christ (1 Cor 12:12-27) is central to Pentecostal ecclesiology. All the members relate to one another, and no member can be spared. These would be people who are emotionally or mentally in dire need. Galatians 6:2 asks all to share the burdens of one another, and this should include taking care of the mentally ill. Mental illness may leave the ill individuals isolated or estranged in the South Asian churches. A biblical picture of the church refutes these trends and encourages inclusion and understanding. Seeing the church as a communion of healing can make members present, supportive, and nonjudgmental.[26] Pastors, elders, and lay leaders can

[25] Christopher E. M. Lloyd, "Contending with Spiritual Reductionism: Demons, Shame, and Dividualising Experiences among Evangelical Christians with Mental Distress," *Journal of Religion and Health* 60, no. 4 (May 15, 2021), https://doi.org/10.1007/s10943-021-01268-9.

[26] Amanda G. Carnes, "Healing Inside Out: The Church and Mental Health," PhD diss., Fuller Theological Seminary, School of Psychology, Pasadena, CA: 2024.

foster an atmosphere that embraces suffering and provides care. When churches practice this care, they mirror the compassion of Christ and become places of emotional and spiritual reprieve, especially to those people who are typically silenced or stigmatized.

In Pentecostal ecclesiology, pastors and elders are viewed as spiritual shepherds responsible for caring for the spiritual well-being of their congregation. All the members are intertwined and none of them is indispensable. This entails individuals who are emotionally or mentally suffering. Galatians 6:2 calls Christians to bear burdens of one another, and this should include the care of people with mental health issues. In most churches in South Asia, people with mental illnesses do not feel welcome. A biblically-based concept of the church is contrary to these trends and encourages inclusion and empathy. Having the church as a group of healing explains the behaviour of being there, supportive, and nonjudgmental to members.[27] Elders, pastors, and other lay leaders are able to establish such a context where suffering is recognised, and relief can be given. When churches embrace that compassion, they become places that echo the compassion of Christ and provide emotional and spiritual shelter, especially to groups of people who are too often discounted or stigmatized.

For Pentecostal churches to effectively address mental health, they must intentionally cultivate safe spaces where vulnerability is welcomed and not judged. This includes preaching that takes emotional struggles into account, establishing forums where an open discussion can take place, and providing resources or referrals. Testimonies must

[27] Clark H. Pinnock, "Church in the power of the Holy Spirit: The promise of pentecostal ecclesiology," In *Pentecostal Ecclesiology* (London: Brill, 2016), 47-64.

contain the testimony of persons who have obtained healing both spiritually and clinically. Worship services, prayer meetings, and pastoral counseling can be shaped to affirm God's presence in all healing journeys.[28] In the case of South Asian churches, this could entail criticising social conventions that consider strength to be synonymous with silence and shame with suffering. Leaders should learn to give empathetic listening, not to use simple solutions, and not to rush to come up with solutions to the suffering members. A church with a great acceptance of brokenness, but one that points to wholeness, can be a powerful place. When prayer, love, education, and care go hand-in-hand, Pentecostal communities can become the location of deep healing for those who are suffering mentally.

Theological Misconceptions and Stigma in South Asian Churches

In this section, I explore how certain theological misunderstandings within South Asian churches have contributed to stigma around mental health. Misinterpretations of Scripture and distorted views of suffering, sin, and faith have often caused people to feel ashamed of their struggles rather than supported. I believe these misconceptions—such as treating mental illness as demonic, as divine punishment, or as a sign of weak faith—have deeply harmed individuals and families, creating silence and isolation. By addressing these false teachings and revisiting biblical truths, I aim to show how the

[28] Justin M. Rasmussen et al., "Congregation Leader and Member Discussions in a Church-Based Family Strengthening, Mental Health Promotion, and HIV Prevention Trial: Intervention," *Global Mental Health* 11 (January 1, 2024), https://doi.org/10.1017/gmh.2024.44.

church can move from judgment to compassion, from stigma to acceptance, and from fear to hope.

Spiritualizing Trauma or Mental Health Conditions as Demonic

In Pentecostal and charismatic churches, it is common to view emotional struggles or mental health conditions as spiritual attacks or demonic possession. Spiritual warfare is an aspect of the Christian religion, although not all mental illnesses are due to demonic influence. This means that a person with a depressive condition would be misinformed that they have a demon and must be delivered, instead of being offered treatments and counseling services.[29] This conviction makes a person very afraid. It can also prevent people from going to therapy or taking medicine, because this way they think that they demonstrate their lack of faith. Spiritualizing all mental illness is detrimental, as it makes the otherwise complex issue simple. Such painful experiences as abuse, loss, or violence usually bring about an example of trauma. The brain and the body bear the scars of these wounds, and prayer may not be the only option that can offer solutions to these problems. Although worship is great and comforting, it should not be used as a substitute for professional care. Churches should know how to distinguish between spiritual wars and mental illnesses.[30] A stable vision that takes into consideration both the spiritual and psychological realities culminates in better treatment of victims.

[29] L. Hamel, "Mental illness and demonization," *Journal of Adventist Mission Studies* 11, no. 2 (2015): 45-77.

[30] Julie J. Exline, Kenneth I. Pargament, Joshua A. Wilt, and Valencia A. Harriott, "Mental illness, normal psychological processes, or attacks by the devil? Three lenses to frame demonic struggles in therapy," *Spirituality in Clinical Practice* 8, no. 3 (2021): 215.

Misinterpretations of Suffering, Sin, and Faith

In many South Asian churches, suffering is often misunderstood as a result of personal sin or weak faith. When an individual encounters a mental health issue, such as depression or anxiety, the community can think that one is spiritually weak or that they are not praying. Some people might think that a firm Christian cannot have emotional problems, and when they have them, that is an indication that they have not given God all the trust that they need to.[31] This thought can be damaging since it would instill humiliation among its sufferers. They might conceal their struggles or not seek help due to the fear of being judged by other people. The Bible reveals that even faithful people undergo tough times.

An example is the righteous man Job, who endured much suffering. As well, David, who had the heart of God, would lament through the Psalms. These illustrations remind us that one can suffer and not have spiritually failed. Misinterpretation of the relationship between suffering and faith provokes guilt and prevents people from achieving healing.[32] As opposed to blame, churches should compassionately give out as Jesus did to the hurting people.

[31] Michal Beth Dinkler, "Suffering, Misunderstanding, and Suffering Misunderstanding: The Markan Misunderstanding Motif as a Form of Jesus' Suffering," *Journal for the Study of the New Testament* 38, no. 3 (2016): 316-338.

[32] Ibid.

Theological Roots of Stigma: Illness as Divine Punishment or Lack of Faith

Another common belief in some South Asian churches is that illness, including mental illness, is a form of divine punishment. It may be the case that people believe that God punishes someone because the individual or their family has done something wrong. This ideology stems back to cultural and theological beliefs of confusing health with righteousness.[33] To illustrate, when one of our members has anxiety or depression, others will offend them by saying that they are sinning or are lacking in faithfulness. Such ways of thinking bring humiliation to the individual and, on other occasions, to the whole family. The stigmatizing beliefs that associate mental illness with sin or lack of faith cause isolation and discourage individuals from seeking help.[34] In John 9, as his disciples inquired about the cause of the blindness of a man, Jesus stated that neither the man nor his parents had committed sins. Jesus' response illustrates that not every pain is a consequence of an evil action. Mental well-being problems may arise due to factors that range from trauma, stress, or even genetic factors, and it does not imply God is angry or far away. Disconnecting suffering from weak faith or sin in church can help dispel the shame and stigma associated with mental illness.

Biblical Correction of These Views

The Bible provides a strong foundation for correcting these harmful beliefs about mental health. In Scripture, there are many examples of men and women of God who

[33] Jennifer Huang Harris, "Mental illness stigma in Christian communities," In *Christianity and Psychiatry* (Cham: Springer International Publishing, 2021), 21-36.

[34] Curtis Lehmann et al., "An Action Research Framework for Religion and the Stigma of Suicide," *Religions* 12, no. 10 (September 26, 2021): 802, https://doi.org/10.3390/rel12100802.

were emotionally troubled. The prophet Elijah was so depressed that he even asked God to kill him (1 Kgs 19:4). But God took no affront. Instead, God pulled Elijah into God's care, and treated him to rest, food, and even restorative time. This demonstrates that God is sensitive to the frailties of human beings and acts with tenderness. Anger, fear, and sorrow are interlaced with forthright pleas of desperation and desolation. David was expressive and very often expressed his emotions to God, and God received his openness. Jesus Christ himself was a sorrowful person who was moved when people were hurting. He never turned away those who were suffering but offered them rest at his side. These examples refute the fact that mental illness is a lapse of spirituality. They show that it is perfectly natural to feel or be not okay and that God is present in the breakdown. Churches have to strictly and continually preach these truths. By making that decision, they can avoid shame with grace, judgment with compassion, and fear with hope.

The Role of Theodicy and Suffering In Theology

In this section, I examine how Christian theology aids in understanding suffering, particularly in the context of mental health. Theodicy, wrestling with why suffering exists if God is loving and powerful, has long been a central question in faith, and it becomes very personal when we consider depression, anxiety, and trauma. Within South Asian churches, mental illness is often misunderstood or linked to sin, which creates judgment rather than compassion. By revisiting biblical teachings, I aim to show how suffering is part of living in a broken world, but not always the result of divine punishment. I also explore how God's presence remains close to those who suffer, how models of healing must include emotional and psychological dimensions, and how suffering can be

integrated into spiritual growth and pastoral care. This perspective provides a healthier foundation for supporting people with mental health struggles in the church.

Understanding Suffering in a Fallen World

Suffering is an inherent part of human life, and Christian theology acknowledges this as a consequence of living in a fallen world.[35] The teaching in Genesis 3 regarding the Fall reveals the cause of sin coming into the world and also the introduction of pain, sickness, and brokenness, including mental and emotional struggles. Theodicy, or the study of why suffering exists despite the existence of a powerful and loving God, is also ushered in. This may be particularly challenging when one has to deal with mental health, which is often not visible and poorly understood.

Some questions that could arise are why God has permitted depression, anxiety, and trauma to exist. It is essential to assert that not all suffering is a punishment by God or failure on the part of an individual. Instead, the sensation of suffering is a reality in the fallen world in which humans exist, whereby the body and the mind are possible targets of suffering. Knowing this enables churches to shun away from the blame game and see the people suffering in a different light. Instead of immediate solutions, theology can create an opportunity to grapple with those problems. By accepting that suffering is not always understood, the church can be more accepting of those who are mentally or emotionally wounded, and thus a more healing place.

[35] John Inge, *A Christian Theology of Place: Explorations in Practical, Pastoral and Empirical Theology* (Milton Park, UK: Routledge, 2017).

God's Presence in Suffering: Lament, Hope, and Pastoral Solidarity

Even while suffering, the Bible shows that God is near. The Psalms have many lamentations; pleadings to God about being hurt, confused, and even angry with God. The prayers help one learn that it is acceptable to be deeply upset and ask God the hard questions.[36] Complaining is not evidence of wavering faith but evidence of the knowledge that God listens. In Isaiah 43:2, God says, "When thou passest through the waters, I will be with thee." This indicates that not all the suffering is removed by God, but God guides people through it. This is a compelling message to people who go through mental health issues. Pastoral care should be given in accordance with this reality. Rather than remove the pain of others all at once, pastors and church leaders have a responsibility to be with those who are in pain, to sit with them, observe, and not direct them on the path of hope without being judgmental.[37] The presence of Christ is present in the ministry of Christ. There are accounts in the gospels of Jesus crying with those who mourned, as well as being right alongside the heartsick. Churches that emulate this mode of pastoral solidarity emerge as the places of comfort, healing, and spiritual nurturing for mentally and emotionally suffering persons.

Models of Divine Healing That Include Psychological and Emotional Dimensions

In many Pentecostal and charismatic churches, healing is a key part of the Christian life. Prayers regarding physical and emotional healing are used frequently; they

[36] M. Elizabeth Lewis Hall, "Suffering in God's presence: the role of lament in transformation," *Journal of Spiritual Formation and Soul Care* 9, no. 2 (2016): 219-232.

[37] Ibid.

can be very comforting to many people. Researchers must not isolate the physical body when practicing healing. True wholeness also encompasses the mind/emotions. In the gospels, Jesus healed the physical, emotional, and social being of a person. As an example, when he healed the bleeding woman (Mk 5), he not only healed her of the physical ailment but restored her sense of belonging, honor, and place in society. This expanded healing paradigm consists of hearing, counseling, communal support, and professional mental health care. It is critical to note that healing may be achieved in many other forms, such as by prayer, therapy, medication, or helpful relationships. God acts in spiritual and medical ways. Mental health is an extension of the healing ministry to the church, which can be done by empowering members to get healing and by congregating with mental care workers. The comprehensive view of healing makes the congregants feel more welcome and comfortable in their way of emotional and psychological healing.

Integrating Suffering into Spiritual Formation and Care

Suffering can shape a person's faith journey and deepen their relationship with God. Although no one wants to experience pain, it is usually a place where people mature in trust, humility, and compassion. As another example, in 2 Corinthians 12, Paul wrote that despite his prayers and requests, God did not remove his thorn in the flesh but allowed him to learn that God's grace was sufficient. This teaches that suffering is not always taken away, but one can change how one understands it.[38] Spiritually, similarly, the mentally ill may be imperfect people, but they can mature and find their reasons to

[38] Carrie Doehring, "Using spiritual care to alleviate religious, spiritual, and moral struggles arising from acute health crises," *Ethics, Medicine and Public Health* 9 (2019): 68-74.

exist. Churches ought to be taught that following God is a combination of happiness and sadness. Spiritual formation should include room to lament, persevere, and heal. Pastoral care groups can contribute by providing Bible classes, support groups, and mentorship programmes, which acknowledge that suffering plays a part in faith. Rather than reading mental illness as an obstacle to spiritual maturity, one could instead understand that mental illness is part of the process. When churches embrace this way of thinking, they develop loving, truthful, and spiritually deeper communities. The solution enables members to draw closer to God during periods of emotional or mental anguish.

Liberation Theology, Cultural Theology, and Contextualization

In this section, I examine how liberation theology, cultural theology, and contextualization provide vital tools for addressing mental health stigma in South Asian churches. Liberation theology challenges oppression and calls the church to stand with those who are marginalized, including individuals struggling with mental illness. Cultural theology emphasizes the need to interpret and apply biblical truths within the cultural values and realities of South Asian communities. Contextualization ensures that theology does not remain abstract but speaks directly to people's lived experiences. Together, these approaches urge churches to affirm dignity, compassion, and justice while reshaping harmful beliefs. By applying these theological frameworks, South Asian churches can create supportive communities where faith and mental health care are integrated for healing and wholeness.

Liberation Theology as a Lens for Deconstructing Stigma and Oppression

Liberation theology is a robust framework that challenges injustice and stands with the oppressed. It originated in Latin America when theologians felt the necessity to address the issues of poverty, violence, and inequality. Regarding mental health, the liberation theology puts the church in mind that mentally ill persons are often treated poorly, are put down, or are neglected. This theology challenges pastors and churchgoers to use their voices to denounce these injustices.[39] In most communities in South Asia, mental illness is stigmatized or considered a spiritual weakness. Liberation theology rebels against this evil thinking. It teaches that all people are created in God's image and deserve dignity, care, and respect, especially those who are suffering.[40] The church has been invited not only to pray over the sick, but also to stand with the suffering, to expose all those cultural and social norms that hurt the human being, and to provide the atmosphere of support and belonging where all people can become safe and welcome. Another point made in liberation theology is that faith is not passive. It is not only spiritual talk but actually taking steps to help the most vulnerable. To the South Asian churches, this must translate to opening up discussions about mental health, eliminating shamefully upheld notions and bringing about sincere empathy to the suffering.

[39] Eve Parker, *Trust in Theological Education: Deconstructing "Trustworthiness" for a Pedagogy of Liberation* (London: SCM Press, 2022).

[40] Joerg Rieger and Priscila Silva, "Liberation theologies and their future: Rethinking categories and popular participation in liberation," *Religions* 14, no. 7 (2023): 925.

Contextual Theology: Applying Theological Truths Within South Asian Cultural Norms

Contextual theology is the process of understanding and practicing the Christian faith in a way that aligns with the local culture. It understands that theology should not be a part of the real world. Mental health has to be approached in a manner that does not undermine the values that are held by South Asian communities, including family honor, respect for elders, and religious devotion, yet does denounce what may be pernicious. Contextual theology helps churches understand where the ideas of culture and theology meet.[41] Another example is that this idea might apply to the South Asian culture, wherein it can be regarded as deferential not to discuss personal cases, though this also may lead to a refusal to seek popularity. The contextual form of theology promotes leaders training their members that seeking mental care is not a sin, but an obligation and love. It also helps churches adapt their practices, language, and preaching to connect with their congregations' experiences. Pastors could, for example, adjust to a cultural education that understands cultural stories or experiences to incorporate gospel teaching about healing and care. Contextual theology does not compromise the truth of the Bible but provides a clarification, making it understandable, pertinent, and humane to a particular culture. This is particularly necessary when attacking the people who feel that mental health is not something that is of their concern, or rather, is a Western idea.

[41] Sigurd Bergmann, *God in Context: A Survey of Contextual Theology* (Milton Park, UK: Routledge, 2017).

Advocating for Dignity, Compassion, and Justice for Those with Mental Health Struggles

The call to treat all people with dignity and compassion is at the heart of liberation and contextual theology. The church must become a place for those with mental health issues where they feel seen, loved, and welcomed.[42] Unhappily, in most churches in South Asia, even silent sufferers are ignored or accused. Pure theology should contribute to justice not only to the poor or the sick but also to those who have their minds affected by stress, depression, anxiety, or trauma. Dealing with the advocacy of justice is speaking up when there is a victim of mistreatment due to mental illness. It also entails transforming church systems that encourage perpetuation of stigma, like silence, fear, or the spread of misinformation. Compassion entails active assistance, including listening and counseling, referral, and education.[43] The church can organize awareness programmes, teach the basics of counseling, pray, and encourage without rejection. By acting to preserve dignity and pursue justice, churches are a place of healing and restoration. This is the heart of Christ, who embraced the fallen, raised the humble, and restored the exiles. The South Asian churches need to have a calling to be frontiers and provide leadership on grace and truth.

[42] Robert Anders, "Dignity in mental health care: human rights challenges and pathways," *Academia Mental Health and Well-Being* 2, no. 2 (2025).

[43] Ibid.

Toward a Theology of Pastoral Care for Mental Health

In this section, I examine how liberation theology, cultural theology, and contextualization provide helpful perspectives for addressing mental health in South Asian churches. Liberation theology challenges stigma and injustice faced by those with mental illness, cultural theology emphasizes applying biblical truths within South Asian cultural norms, and contextualization ensures theology speaks directly to the lived realities of the community. Together, these approaches guide the church to promote dignity, compassion, and justice.

Pastoral Theology

Pastoral care refers to the support, guidance, and spiritual encouragement offered by church leaders to individuals in times of need. It is based upon the ministry of Jesus, who had great compassion for the hurting and the broken. Pastoral care at its root is not necessarily about preaching or even teaching; it relates to being with the people on their life-pathways, in times of combat and struggle. This care involves offering emotional services, prayer, morale-boosting, and having a consistent presence during times of trouble.[44] An understanding of mental health in pastoral care includes the fact that individuals can be silently suffering and providing a space where they feel listened to and understood. The ethics of pastoral care involve respect, presence, compassion, and confidentiality. These principles inform pastors on how to approach persons in a state of

[44] Nancy J. Ramsay, ed. *Pastoral Theology and Care: Critical Trajectories in Theory and Practice* (Hoboken, NJ: Wiley & Sons, 2018).

distress. When properly practiced, pastoral care can make the affected persons feel that they are not alone; that their church and God do care about their pains and the hardships they are facing.

Pastors serve as spiritual caregivers who help guide their congregants through difficult emotional and spiritual seasons. They are not psychologists or doctors, but they play a significant role in emotional and spiritual healing. A pastor can serve as a healer by encouraging and praying, guiding with their input of biblical wisdom, and being comforted by just being present during times of suffering.[45] Most members of the church confide in their pastors as opposed to consulting experts. The role of the pastor is critical in this situation because they determine when a person requires additional attention and provide an inviting atmosphere, ensuring people feel free to talk. The listening ear of a pastor, spiritual guidance, and having a constant presence to the troubled mental health patient can change the life of a troubled person. It is often in these human interactions that healing commences. If pastors are able to serve with humility and openness, they create a loving presence for God in the hurting ones.

A strong pastoral care model must bring together theology and psychological understanding. The causes of mental illness are not only spiritual: it is biological, emotional, and psychological. Pastors should also be armed with a rudimentary knowledge of mental health so they can be in a better position to understand members of their congregation.[46] Psychological inputs into theological care do not imply that science

[45] Ibid.

[46] Ibid.

should outlaw faith but rather have a complementary approach that does not compromise the difference between science and faith. Instead, it is a view that both are needed as instruments God can utilize to bring healing. Theology brings meaning, hope, and destination. Psychology can provide an understanding of how the mind works and why there is healing. Combined, they enable the pastor to more intelligently and effectively respond.

An example might be a pastor praying with an anxious individual and telling them to talk to a counselor. This moderated thinking upholds the significance of faith as well as the usefulness of mental care. It also aids in decreasing stigma and displays that seeking help is not only an obedient step towards healing but also a faithful step.

Theology of Presence and Listening

Incarnational ministry means being present with others in their suffering, just as God came to be with humanity in Jesus. Jesus did not keep a distance from human suffering.[47] He was with the sick, the lonely, the brokenhearted. Similarly, pastors are also required to be in the presence of the people who are in pain, not in their healing processes, but to support them by joining them with love and understanding. Such presence is a representation of God, tangibly showing love and caring.[48] A person's presence can bring comfort and peace to another when they are facing mental health issues. There is little communication in such a ministry of presence; in fact, it may be full

[47] Samuel Wells, *Incarnational Ministry: Being with the Church* (Grand Rapids, MI: Eerdmans, 2017).

[48] Ibid.

of silence, prayer, and being emotionally available. Sitting with people in their suffering is a sacred task, as it helps humans to experience that God is with them in the midst of their suffering, when they are feeling lost or alone.

Hospitality, according to Christianity, is beyond inviting someone into one's home; instead, it is opening one's heart and community to give someone a feeling of safety, acceptance, and a place of worth. Empathy is putting oneself in the position of a person being affected by what they are going through and experiencing their pain as one's own.[49] Both hospitality and kindness are tangled in Scripture and theology. Jesus had the ways to give hospitality, such as opening his doors to those who were shunned by society, and his sympathy, which was shown through crying with those who cried. Personal characteristics such as these are used in pastoral care. Mental illness may leave a person feeling isolated and not wanted or understood. When a church or a pastor manifests hospitality and empathy, they penetrate that isolation. Such habits send the message that they are essential and cared for by others.[50] This leaves the possibility of healing, trusting, and becoming involved in deeper relationships. In such a manner, the concepts of hospitality and empathy are employed as spiritual methods to heal the minds and spirits of people.

[49] Amos Yong, "Hospitality and Religious Others," *A Charitable Orthopathy: Christian Perspectives on Emotions in Multifaith Engagement* (2020): 183.

[50] Ibid.

Pastoral Ethics and Responsibility

One of the most critical responsibilities of a pastor is maintaining trust, especially when someone shares personal or painful struggles. Anonymity is essential; individuals must feel sure that their story is cared for and guarded. Simultaneously, pastors should learn to refer an individual to a professional counselor, doctor, or psychologist.[51] Asking is neither a sign of failure nor wisdom; it is a sign of care. Cooperation with mental health professionals enhances the assistance that a church can give. By establishing mutual partnerships between Christian therapists or mental health agencies and pastors, a divide between religious and mental well-being is bridged. This strategy of involving teams assures individuals that they do not have to decide between going to church and getting help through therapy.[52] This situation can be managed ethically and respectfully, as it shows the pastor has integrity and the church is a healing and safe environment.

Theological education should prepare pastors not only to preach but also to care for the whole person.[53] Unfortunately, in most pastoral training, mental health education is absent altogether. This pastor is unready to emotionally and psychologically face the actual and action-oriented struggles of the congregants. Seminaries and Bible colleges should begin to incorporate introductory classes on mental health, such as classes on depression, trauma, and anxiety, to enable a pastor to recognize potential issues and know

[51] W. Ross Hastings, *Pastoral Ethics: Moral Formation as Life in the Trinity* (Eugene, OR: Wipf & Stock, 2025).

[52] Ibid.

[53] Mark Dickerson Mehlig, "Pastoral Care Training: Equipping Pastoral Staff to Effectively Minister to the Local Community," Doctoral Dissertation (Lynchburg, VA: Liberty University, 2021).

what to do.[54] This preparation should also include an examination of how theology can aid in mental wellness, and how pastors can combine Scripture, prayer, and spiritual care with emotional care. When well-trained, pastors become a lot more confident, caring, and helpful within their ministry.[55] They can walk more with people through difficult times and build churches where mental health is taken seriously and dealt with love. This training enables pastors to be spiritual leaders and caring fellows.

Summary and Theological Implications

In this chapter, I examined the essential theological foundations required for understanding and addressing mental health within South Asian churches in North America. I developed a well-rounded perspective to incorporate faith, psychology, and cultural sensitivity through relying on essential biblical teachings, theological, and pastoral care concepts. I began with answering the question of why theology is necessary in the mental health discourse because beliefs about God, suffering, healing, and human dignity are primary shapers of how churches approach mental illness. In communities of color, especially those that are South Asian and are burdened by stigmatization, silence, and spiritual misunderstanding negatively affecting behavior, a theologically informed approach is not optional, but necessary. Some of the most important biblical themes, including humans being created in the image of God (*imago Dei*), the compassion of God towards the brokenhearted, and the ministry of Christ to those who are afflicted, testify to

[54] Ibid.

[55] Kristen E. Paul, "Sacred Minds: The Need for Mental Health Awareness Training for Priests: Supporting Clergy and Parishioners," *Anglican Theological Review* (2025): 00033286251357180.

the value and dignity of each person, which is not withheld even to individuals who may be downtrodden by mental health issues. As can be seen in Genesis to the gospels and Paul's letters, emotional wholeness and spiritual wholeness are always issues that are evident in God. As the Bible shows, suffering is not a punishment of God or an indication of a weak faith, but rather one of the human problems. Such foundations can tear down ignorant notions that mental illness is caused by personal sin or spiritual failure.

In this chapter, I also introduced three theological frameworks: Pentecostal/charismatic, pastoral, and liberation, offering distinct but complementary insights into mental health care. Pentecostal theology prioritizes healing and prayer and the presence of the Holy Spirit but should be practical and include emotional attention. Pastoral theology concentrates on the work of the caregiver and should be accompanied by listening, presence, and empathy. Liberation theology is questioning the church to promote justice, inclusion, and compassion to those who are negatively affected, such as the mentally ill. Comprised together, these frameworks can help church leaders to redefine mental health as not a burden to heal, but a sacred domain of healing, dignity, and accompaniment. In addition, I discussed in this chapter the tremendous cost of theological misunderstandings within the South Asian churches, which include believing mental illness is demonic, punishment by a god, or a faithless person. Such interpretations tend to bring more stigma, and people prefer not to seek help. Such ideas must be corrected using good theology. The theodicy and suffering section affirmed the fact that God is not an absentee when one is in pain. Instead, God is close and full of hope. God is urging the church to accompany sufferers and follow them through the

context of pastoral accompaniment. This theological perspective leaves room to lament, be supported, and grow.

Ultimately, I developed a theology of pastoral care centered on presence, ethical responsibility, and the integration of theological reflection with psychological insight. Pastors are supposed to listen, guide, and advocate for their congregations, as well as preach. The skills to collaborate with mental health professionals, uphold confidentiality, and be able to respond to others compassionately are key in achieving healthier and more supportive church communities. The theological reflections here provide ideas about practical strategies I present in chapter 4, which centers on ministry practice. Theology is more than a belief system; it is an action plan. It envisages the way church leaders should address the issue of mental illness, the response of the congregants to that suffering, and the way communities can increase love, justice, and care. Theology provides a guide to building congregations in which healing is spiritual, emotional, and social.

Chapter 4

Ministry Practice

In this chapter, I explore and develop practical ministry strategies that address mental health concerns within South Asian Pentecostal and charismatic churches in North America. I examine the specifics of the application using the theological foundations provided in chapter 3. The key aim is to provide congregants, church leaders, and pastors with spiritually faithful but effective tools and models of care. I show how churches can create places where people with mental health difficulties can feel safe and an environment where they are nurtured. By including the three (compassion, wisdom, and cultural awareness) as the foundational aspects of the ministry, in this chapter, I create a setting where healing is sought in the light of a whole person, through prayer, presence, support of the community, and collaboration with professionals.

Mental health remains a sensitive and often misunderstood topic in many South Asian church communities. Spiritual forms of care, such as prayer and worship, may be helpful for emotional comfort. Still, it is often considered the sole means of care that fails to address emotional and psychological needs. This needs practical strategies of ministry. Without practical strategies, theological reflections are far-fetched, and people suffer in silence. Leaders and pastors should preach hope and know how to respond appropriately when a Christian finds themself in a difficult time. These methods assist in overcoming the gap between spirituality and the psychology of human suffering, with the church being able to respond in a vivid, competent, and caring manner.

In chapter 3 I provided a firm basis for discussing Pentecostal/charismatic, pastoral, and liberation theology, which addresses the church's call to care, heal, and advocate. Nevertheless, theology has to be embodied in ministry practice. In this chapter, I close that distance by applying theological language to practical ministry practice, including the image of God, presence, lament, and healing. I base this on Scripture, and cultural and pastoral insights to present tools that are congruent with both the biblical truth and those in mental health care. The goal is to help churches see that caring for mental health is not outside their mission but is a core expression of God's love and justice for all people.

South Asian churches in North America operate within a unique context shaped by immigration, cultural identity, theological heritage, and generational change. Most of these churches are Pentecostal or charismatic, focusing on the powers of the Holy Spirit, healing, and passionate worship. Although such traditions are full of rich spiritual zeal, they are sometimes burdened with theological presumptions, making mental health care difficult. Also, cultural norms of family honor, shame, and silence do not facilitate open discussions of emotional suffering. In this chapter, I directly relate the configurations of ministry in this context that provide culturally specific and theologically based formats that answer the unique needs of South Asian congregations.

Current Practices in South Asian Churches

In this section, I explore the current models and practices of pastoral care within South Asian Pentecostal and charismatic churches in North America. These practices often emphasize prayer, fasting, deliverance, and pastor-centered leadership, reflecting

both cultural traditions and theological beliefs. While these approaches offer strong spiritual and communal support, they also reveal significant weaknesses, such as lack of mental health literacy and an overemphasis on spiritual explanations. By looking at these practices, their strengths, and their limitations, one can better understand the urgent need for more balanced, informed, and collaborative ministry approaches that integrate both faith and psychological care.

Standard Models of Pastoral Care Currently in Use

In many South Asian Pentecostal and charismatic churches in North America, pastoral care is primarily shaped by spiritual authority, cultural norms, and theological assumptions. Pastor-centered care is the most popular model where the senior pastor acts as the central spiritual authority and advisor to congregants, addressing their personal and spiritual issues.[1] Pastors are frequently sought out to pray, counsel, and bless during a crisis, including those related to mental health problems. Another model entails family-based pastoral care, whereby families mediate between the church's pastoral leadership and church members.[2] Medications and other sensitive issues, including depression and anxiety, may be first resolved at the family level, and only spiritual issues brought to the pastor.

[1] Neil Pembroke, "Christian Pastoral Care as Spiritual Formation: A Holistic Model for Congregational Ministry," *Religions* 16, no. 5 (May 13, 2025): 618–18, https://doi.org/10.3390/rel16050618.

[2] Xolisa Jibiliza, "The Evolution of Pastoral Care Ministry through the Ages," *Pharos Journal of Theology* 102 (February 2021), https://doi.org/10.46222/pharosjot.10211.

Some churches are beginning to adopt small group ministry models, where care is provided in cell groups or fellowship groups, usually organized by gender, age, or life stage. These groups provide both relational support and basic pastoral oversight. The leaders of such groups, however, possess little or no training in mental health. A deliverance ministry model is also prevalent among the Pentecostal contexts. In this context, those who experience suffering are normally blamed on spiritual oppression, and the interventions are concentrated on spirit warfare, fasting, and deliverance rituals. All these models differ in formality and performance but continue to prevail by very long-held theological and cultural traditions. On the one hand, they represent a high level of communal and spiritual norms; on the other, they are usually not integrated with either psychological support, clinical referrals, or evidence-based mental health strategies.

Spiritual Care Approaches: Prayer

Prayer is the most widely used spiritual care practice in South Asian churches. This is the initial and most likely only reaction to mental, emotional, or spiritual discomfort. Pastors and elders regularly pray over those who are anxious, depressed, or traumatized with the thought that God would do a miracle to fully heal them. Individual, intercessory, and corporate praying meetings are healing tools. Prayer gives much comfort, spiritual connection, and hope. Only using prayer can, however, postpone or substitute clinical care. When suffering continues, one may feel guilty/ashamed because they do not have enough faith.[3] Although spiritually rich, the practice can become

[3] Margaret Fitch and Ruth Bartlett, "Patient Perspectives about Spirituality and Spiritual Care," *Asia-Pacific Journal of Oncology Nursing* 6, no. 2 (2019): 111, https://doi.org/10.4103/apjon.apjon_62_18.

ineffective and even harmful when isolated from a situation that deprives it of the benefits of professionally supported help.

Spiritual Care Approaches: Fasting

Fasting is another practice rooted in Pentecostal South Asian communities. It is usually seen as a way for the individual to receive spiritual insight, resolve sin, or experience a breakthrough through God. Sometimes, the congregants are advised to fast in case they have emotional burdens or mental torment. Fasting is believed to strengthen one's connection with God, and in cases of mental distress, it is assumed that fasting can lead to spiritual release and restoration.[4] Although fasting can help build discipline and give one time to reflect, it can also worsen issues in psychology. An individual who is diagnosed with clinical depression can be instructed to engage in fasting instead of talking to a therapist. This may aggravate both physical and mental symptoms, particularly when the person is already experiencing fatigue, hopelessness, or has contemplated self-harm or suicide. Fasting alone as therapy can turn spiritually and emotionally harmful without a balance in coaching.

Spiritual Care Approaches: Deliverance

Deliverance ministry is a distinctive feature in many Pentecostal churches, including those in the South Asian community. It is regularly administered as mental or

[4] Khaled Trabelsi et al., "Religious Fasting and Its Impacts on Individual, Public, and Planetary Health: Fasting as a 'Religious Health Asset' for a Healthier, More Equitable, and Sustainable Society," *Frontiers in Nutrition* 9, no. 1 (November 24, 2022), https://doi.org/10.3389/fnut.2022.1036496.

emotional conflict is considered a spiritual assault or demonic action of oppression. Deliverance consists of praying sessions, laying on of hands, and rebuking evil spirits. Congregants who are traumatized, anxious, or psychotic are subjected to deliverance rituals with the belief that they are victims of spiritual oppression. Although deliverance can give a spiritual breakthrough to people, it may cause many problems when not discreetly exercised.[5] Mental illnesses can be misinterpreted as demonic, resulting in fear, shame, or a lack of medical attention. This is because deliverance sessions are repeated on other occasions, but one non-improvement prospect makes those delivered think they are spiritually deficient.[6] Without pastoral wisdom and clinical insight, this practice could give rise to spiritual abuse or a drop in the number of persons who could seek psychological treatment.

Strength of the Traditional SA Models: Strong Spiritual Support and Community

One of the greatest strengths of South Asian churches is their sense of community and spiritual support. Congregants have networks of people who encircle them with care through prayer, visits, and closeness in the bad times. This attachment support gives the feeling of belonging and minimizes isolation. Many patients with mental problems find solace in belonging to a church family, and this helps to give them a sense of direction.

[5] Ana Patrícia Tavares et al., "Spiritual Comfort, Spiritual Support, and Spiritual Care: A Simultaneous Concept Analysis," *Nursing Forum* 57, no. 6 (November 30, 2022), https://doi.org/10.1111/nuf.12845.

[6] Tracy A. Balboni, Tyler J. VanderWeele, Stephanie D. Doan-Soares, Katelyn NG Long, Betty R. Ferrell, George Fitchett, Harold G. Koenig et al., "Spirituality in serious illness and health," *Jama* 328, no. 2 (2022): 184-197.

Pastors and elders are especially good givers of time and presence, and these gifts' therapeutic power can be manifold. This spiritual and social structure can help heal much when supported by proper care.[7] Because churches can provide long-term support, personal relationships, and spiritual hope to people undertaking clinical treatment, they are uniquely situated to supplement care.

Weakness of the Traditional SA Models: Lack of Mental Health Literacy

A major weakness in current ministry practice is the lack of mental health awareness and training among pastoral leaders. The majority of pastors and lay leaders have not been trained to look out for any signs of depression or anxiety, trauma, or suicidal thoughts and ideation.[8] Therefore, a good number of the mental health conditions are not identified or are mistaken for spiritual problems. Congregants can be urged to pray more or repent, instead of being advised to seek medical assistance. This information black hole perpetuates stigma and makes early intervention tougher. Moreover, most churches do not maintain ties with mental health practitioners, thus leaving the pastors without referrals. Without deliberate training and liaisons, churches may end up mismanaging delicate mental health issues, thereby aggravating the situation of affected people.

[7] C. Estelle Smith, Avleen Kaur, Katie Z. Gach, Loren Terveen, Mary Jo Kreitzer, and Susan O'Conner-Von, "What is spiritual support and how might it impact the design of online communities?" *Proceedings of the ACM on Human-Computer Interaction* 5, no. CSCW1 (2021): 1-42.

[8] Samuel Dossa Morgamo, *Implementing an Adult Mental Health First Aid Program in a Church Setting to Improve Mental Health Literacy and Reduce Mental Health Stigma: An Evidence-Based Project*, (Bloomington, MN: Rasmussen University, 2023).

Weakness: Overemphasis on Spiritual Explanations

Another significant weakness is the over-spiritualization of mental health conditions. Emotional and psychological struggles are all defined in a spiritual context in most South Asian Pentecostal churches. Terms such as spiritual attack and the idea of a generational curse or demonic power are also used to explain what may have been clinical depression, post-traumatic stress disorder, or anxiety. All suffering should not be reduced to spiritual warfare since it misleads care and hurts people. This can be a stigmatizing experience for people with mental illness, giving them the feeling that they are deficient in faith or morally weak.[9] It also discourages the application of therapy, medication, or psychiatric assistance. The church can continue the ethos of shame unless it has a balanced perspective incorporating spiritual and psychological perspectives promoting healing.

Case Example: The Story of Naomi Isaac

Naomi Isaac,[10] a second-generation South Asian woman in Toronto, grew up in a devout Pentecostal household. When she lost her job and had a negative breakup, she started to have symptoms of depression, withdrawal, sleeplessness, and hopeless thoughts. By the time she had gone to her church leaders and sought their intervention, they had concluded that this was a spiritual attack, and thus they advised her to pray and fast. Naomi attended various deliverance meetings, and yet she deteriorated. Completely

[9] Gabriela Picciotto, Jesse Fox, and Félix Neto, "A Phenomenology of Spiritual Bypass: Causes, Consequences, and Implications," *Journal of Spirituality in Mental Health* 20, no. 4 (December 28, 2017): 333–54, https://doi.org/10.1080/19349637.2017.1417756.

[10] Pseudonym.

defeated spiritually and emotionally burnt out, she attempted suicide. She survived and was admitted to a hospital where she was diagnosed with major depressive disorder. It was only after her hospitalization that her family realized her sickness was grave. Subsequently, Naomi received encouragement when she was provided with a Christian therapist who liaised with her pastor. Collectively, they devised a plan of care involving therapy, medications, and spiritual mentorship. Her case provides an example of the risk when treating mental illness without acknowledging the spiritual component and the effectiveness of combined care. When churches partner with mental health professionals, healing is possible without compromising one's faith.

Gaps and Barriers in Ministry Practice

In this section, I examine the major gaps and barriers that limit effective mental health ministry in South Asian Pentecostal and charismatic churches. While these congregations provide strong spiritual support, they often struggle with limited pastoral training, stigma shaped by theological misconceptions, lack of collaboration with mental health professionals, and deep-rooted cultural taboos related to honor, gender, and family reputation. Additionally, hierarchical church structures sometimes restrict open dialogue and hinder the development of supportive mental health initiatives. By identifying these challenges, it becomes clear that meaningful progress requires intentional training, cultural sensitivity, and structural reforms that allow for more integrated and compassionate care.

Lack of Training and Mental Health Literacy Among Pastors

One of the most pressing gaps in South Asian Pentecostal and charismatic churches in North America is the limited training that pastors receive on mental health issues. Clergy are trained to be comfortably conversant in biblical teaching, prayer, and spiritual direction. Nevertheless, there are still high numbers of people lacking the professional background in recognizing and managing mental health issues like anxiety, depression, trauma, and addiction.[11] This illiteracy allows the pastors to misinterpret clinical signs as spiritual issues or moral sins and thus tend to offer spiritual solutions instead of medical or psychological treatment. Pastors who are unsure how to diagnose and treat suicidal ideation, PTSD, or panic attacks may lack the knowledge of risk factors to take advantage of to save the congregants in case they arise. Also, they might feel ill-equipped and scared to deal with complicated emotional issues and tend to use generic prayer or Scripture without recommending resources within the community.[12] Lack of training deprives the quality of care, inadvertently leading to (perpetuating) stigma and diminishing the truth within the church.

Stigma and Theological Misconceptions Revisited in Practice

Theological misconceptions surrounding mental illness continue to influence how pastors and congregants respond to suffering within South Asian church communities.

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[11] Jessica Haughton et al., "Identifying Barriers, Facilitators, and Implementation Strategies for a Faith-Based Physical Activity Program," *Implementation Science Communications* 1 (June 8, 2020), https://doi.org/10.1186/s43058-020-00043-3.

[12] Ibid.

Notions such as mental illness is a punishment by God or depression signifying weak faith are still held by the majority, whether publicly or otherwise. Such perceptions give rise to stigmatizing terms, denial of emotional suffering, and the feeling that one must maintain a spiritually resilient image.[13] Those in need of help with their mental health issues feel judged, isolated, or that no one can hear them. They do not find comfort in their church because they may feel afraid of being gossiped about, rejected, or ashamed. Such stigmas do not occur in the abstract but are lived out in everyday ministry, whereby emotional issues are downplayed or refocused on spiritual performance (fasting or deliverance). Without a theology of human brokenness, the need to be complex in addressing suffering, the need to acknowledge that suffering requires both spiritual and psychological care, churches perpetuate hurtful attitudes that hamper the healing process and discourage people from showing vulnerability.

Limited Collaboration with Mental Health Professionals

Another significant barrier in ministry practice is the minimal collaboration between South Asian churches and mental health professionals. Pastors can be unfamiliar with Christian counselors, therapists, and social workers, and they may not always understand how or when to send a congregant to a professional. In most instances, churches are not part of the health sector as they consider it secular, unspiritual, and

[13] Curtis Lehmann et al., "An Action Research Framework for Religion and the Stigma of Suicide," *Religions* 12, no. 10 (September 26, 2021): 802, https://doi.org/10.3390/rel12100802.

culturally inappropriate.[14] Other pastors fear that mental health professionals are not going to listen to or comprehend the religious and cultural reality of their congregants. Such fear creates isolation and the loss of opportunities for integrated care. In the absence of adequate referral services or trusted collaborations, congregants needing clinical intervention beyond spiritual support lack access to clinical intervention. Such a lack of cooperation does not enable the church to be involved in a wider care network, and it strengthens the idea that prayer is the only acceptable help.[15] Effective professional pastoral care has to incorporate bridges into professional care of the whole person.

Cultural Taboos and Gender Dynamics Impacting Mental Health Care

Cultural norms around shame, honor, and family reputation deeply affect how mental health is perceived and addressed in South Asian communities. Emotional conflicts are mostly concealed to defend the image of the family, particularly among women and older people.[16] In a patriarchal family, women could not speak out and were not allowed to consult a therapist without the consent of a husband or a father. Older generations may interpret mental illness as a weakness or a sign of failure in an individual, creating a lack of incentive in the younger generations to speak about their feelings. Because of this, many experience the symptoms silently, particularly women,

[14] Wendy Shoesmith et al., "Barriers and Enablers to Collaboration in the Mental Health System in Sabah, Malaysia: Towards a Theory of Collaboration," *BJPsych Open* 6, no. 1 (December 12, 2019), https://doi.org/10.1192/bjo.2019.92.

[15] Ibid.

[16] Lufuluvhi M. Mudimeli and Hundzukani P. Khosa-Nkatini, "Cultural Dynamics of Gender-Based Violence and Pastoral Care in South Africa," *HTS Teologiese Studies / Theological Studies* 80, no. 2 (2024): 7, https://hts.org.za/index.php/hts/article/view/9353/27053.

who juggle the needs of family, church, and work, whilst being unable to diagnose their emotional pain. Men are also afraid of reaching out as they are afraid that they will be judged or be considered weak. Orthodox explanations of somatic suffering tend to reinforce such taboos by their explanation in terms of sin or spiritual ill-adaptation.[17] Without culturally sensitive programming and gender inclusive spaces churches can contribute to this silent and painful suffering, of people who are already marginalized.

The Role of Church Structure in Limiting Access or Response

The hierarchical leadership in most South Asian churches may inadvertently put up obstacles to mental health assistance. The decision-making process is usually centralized; that is, one senior pastor or a handful of elders are the only ones who can access decisions, which may or may not be open to psychiatric issues.[18] When the person who is in a significant leadership position is uninformed, paranoid, or sarcastic, their attitude may extend to the entire congregation. Moreover, lay leaders or newer pastors can lack the authority to launch new programs such as the mental health workshops, counseling groups, or partnerships with professionals. It can also rule out free discussion or creativity because of the concern with obeying authority. Moreover, the church could lack clear structures or policies on how to proceed in handling mental health crises, and there could be no referral guidelines, confidentiality, or a pastoral response.[19] Support,

[17] Ibid.

[18] Judith Hahn, "Dissent as Deviance: Sociological Observations on Structural Conflicts in Church," *Pathways for Ecumenical and Interreligious Dialogue*, January 1, 2024, 103–21, https://doi.org/10.1007/978-3-031-56019-4_7.

[19] Lehmann et al., "Hospitality towards People with Mental Illness in the Church," 1–27,

which is well-intended in such an environment, can be inconsistently provided, poorly informed, or even harmful. More open and collaborative models of church structure should be considered vital to creating effective and inclusive mental health ministries.

Building a Culturally Sensitive Mental Health Ministry

In this section, I focus on how South Asian Pentecostal and Charismatic churches can build a mental health ministry that is both theologically faithful and culturally sensitive. Ministry in these contexts must acknowledge the cultural values of family, honor, respect for elders, and community while also addressing the stigma that surrounds mental illness. A culturally sensitive ministry seeks to integrate biblical teaching with practical frameworks of mental health care, creating safe spaces where vulnerability is welcomed and compassion is practiced. It must also include women, youth, and the elderly, ensuring no group is left unheard. By promoting empathy, hospitality, and justice, churches can embody the love of Christ while supporting emotional and psychological wholeness within their communities.

Principles of Contextualized Pastoral Care for South Asian Congregations

A culturally attuned psychological ministry starts by doing culturally appropriate pastoral care that resonates and is relevant to the historical experiences, customs, and dogmas of South Asian congregations in North America. Contextualized care recognizes that faith, family, and cultural heritage play a role in understanding illness, healing, and

community.[20] This strategy would allow the ministry to alter its practices to sound compelling to the congregants and preserve biblical integrity and theological accuracy. As an illustration, the pastors can use common cultural stories, languages, and other illustrations to teach mental health concepts. Contextualization should also meet the family's needs, honor, and intergenerational expectations. Pastors should pay close attention to the unique issues faced by immigrants, first-generation parents, and second-generation young people without a blanket approach.[21] Cultural identity is important, even when we bring change to harmful norms, to allow care to feel authentic, trustworthy, and transformative. The goal of contextualized pastoral care is that mental health ministry cannot and is not imported but must be developed within the community.

Integrating Theology with Cultural Values and Mental Health Frameworks

For a mental health ministry to be effective in South Asian churches, theology must be integrated with cultural values and evidence-based frameworks in mental health. This integration fills in the gap between biblical and psychological wisdom, which would help pastoral leaders provide care that touches the entire person, including their body, mind, and spirit.[22] One example is theological declarations of humanity's sacredness,

[20] Diana L Swihart, Romaine L Martin, and Siva Naga S. Yarrarapu, "Cultural Religious Competence in Clinical Practice," National Library of Medicine (Tampa, FL: StatPearls Publishing, 2023), https://www.ncbi.nlm.nih.gov/books/NBK493216/.

[21] Francesco Molteni and Frank van Tubergen, "Immigrant Generation and Religiosity: A Study of Christian Immigrant Groups in 33 European Countries," *European Societies* 24, no. 5 (March 3, 2022): 1–23, https://doi.org/10.1080/14616696.2022.2044067.

[22] René Hefti, "Integrating Religion and Spirituality into Mental Health Care, Psychiatry and Psychotherapy," *Religions* 2, no. 4 (November 2, 2011): 611–27, https://doi.org/10.3390/rel2040611.

which view people as bearers of the image of God, meshed with culture-sensitive counseling strategies that acknowledge the importance of family integrity and respect for the elderly. Biblically accessible concepts can be employed to lend a certain relevance in mental health training in a manner that is apt to the South Asian spirituality as well as dismissing the false beliefs that mental illnesses are products of sin or demonic possession. By connecting culturally competent mental health practitioners who can provide practical coping skills, therapeutic referrals, and spiritual guidance to people compatible with them spiritually, the pastor can help. This kind of balanced approach means that theology does not dismiss the necessity of psychology, and the latter cannot ignore spiritual identity.

Creating Safe Spaces for Vulnerability and Sharing

Safe places in church must play an important role in shattering the stigma and silence of mental illness. This is where people find settings (this may be in small-groups, prayer circles or even workshops) where they can openly confess their problems without fear of not being judged or talked about by other people.[23] In South Asian settings where family honor and reputation are prioritized over personal health, these spaces need to be strategically developed where discretion and trust are implied. Leaders and pastors can also exemplify vulnerability by offering personal testimonies regarding emotional

[23] Marina Trowell, "The Importance of Safe, Brave and Facilitated Spaces in Student-Staff Partnerships—Finding a Space for Compassion," *Pastoral Care in Education (Print)*, March 3, 2024, 1–22, https://doi.org/10.1080/02643944.2024.2322534.

struggles, which helps them see renouncing help as a sign of weakness.[24] Through facilitated guides led by trained mental professionals or pastoral caregivers, the congregants can healthily work through their feelings. Safe spaces open the space to prayer, encourage, and support each other. Once church members realize that they can talk without shame, they tend to get help early before pain can develop into serious crises.

Promoting Empathy, Hospitality, and Compassion in Church Culture

A mental health-supportive church culture must be rooted in empathy, hospitality, and compassion. Empathy allows leaders and members to understand the suffering of others spiritually and emotionally, whereas hospitality provides a setting where members can feel accepted, special, and loved.[25] In South Asian churches, where community life is central, hospitality can be a very effective inclusion tool, welcoming people into homes, sharing a meal, and offering people who are distressed a listening ear. Compassion does not stop at sympathy: good care requires action in the part of the church (e.g., arranging hospital visits, preparing meals during treatment, or even providing transport for a therapy session). Pastors are allowed to preach and teach on biblical cases of empathy and compassion, like the story of the Good Samaritan, which they can correlate with real-

[24] Remiel Lockwood, "Pastoral Stress: The Urgent Need for Self-care," 2020, https://digitalcommons.liberty.edu/cgi/viewcontent.cgi?article=3633&context=doctoral.

[25] Mwansa Claude Kimpinde, "Dispassionate Hospitality as a Christian Value: A Pastoral Narrative," *HTS Teologiese Studies / Theological Studies* 80, no. 1 (2024): 8, https://hts.org.za/index.php/hts/article/view/9936/27964.

world mental health issues.[26] With these values inculcated in the text of sermons, in the forms of ministries, and through informal interactions, the churches can transform stigma into care.

Including Women, Youth, and the Elderly in Ministry Efforts

A culturally sensitive mental health ministry must intentionally involve women, youth, and older people, as each group faces unique challenges and contributes valuable perspectives.[27] South Asian women are highly burdened by caregiving and cultural roles and thus are more susceptible to experiencing emotional distress, and are capable of informing their families about mental health. Youth experience the pressures of intergenerational expectations, identity issues, and academic pressures, and need ministries that accommodate cultural group identity and psychological health. The older generation can be challenged by loneliness, long-term conditions, or adjustment to a new cultural setting in Canada/USA, but they are also the guardians of cultural practices.[28] Ministry initiatives must develop intergenerational programs promoting discussion, mentoring, and support. Engaging all demographics, churches stir the message that

[26] Lehmann et al., "Hospitality towards People with Mental Illness in the Church," 1–27,

[27] Petr Cincala and Allison Sauceda, "Number 2 Fall Article 9 Part of the Practical Theology Commons Recommended Citation Recommended Citation Cincala, Petr and Sauceda," *Journal of Applied Christian Leadership Journal of Applied Christian Leadership* 13, no. 2 (2019): 100–110, https://digitalcommons.andrews.edu/cgi/viewcontent.cgi?article=1454&context=jacl.

[28] Jenny De Jong Gierveld, Suzan Van der Pas, and Norah Keating, "Loneliness of Older Immigrant Groups in Canada: Effects of Ethnic-Cultural Background," *Journal of Cross-Cultural Gerontology* 30, no. 3 (May 16, 2015): 251–68, https://doi.org/10.1007/s10823-015-9265-x.

mental health is not a matter privately contained to individuals but a common issue that penetrates all people of the faith.

Training and Equipping Pastors and Church Leaders

In this section, I focus on the importance of preparing pastors and church leaders to respond wisely and compassionately to mental health needs within South Asian congregations. Since pastors are often the first people approached during crises, they must be equipped with the knowledge and skills to recognize mental health struggles, offer spiritual care, and connect individuals with professional help when needed. Training programs provide essential awareness of conditions such as anxiety, depression, and trauma, while also addressing sensitive areas like suicide prevention and professional boundaries. Through structured curricula, workshops, continuing education, and partnerships with mental health professionals, pastors can grow in competence. Theological seminaries further strengthen this effort by embedding mental health into pastoral formation.

Developing Mental Health Awareness and Competence

For pastors and church leaders in South Asian congregations, developing mental health awareness and competence is a foundational step toward effective ministry. The key to awareness can be found in knowing what mental health is and how it is different from mental illness, as well as acknowledging that emotional health is as essential as

physical health.[29] Competence entails more; it involves being able to learn how to recognize indicators of typical mental health issues, (e.g., depression, anxiety, trauma responses, as well as stress-related disorders), and know how to respond to them. Pastors should be trained on how to give spiritual comfort and decide when someone need the services of a professional.[30] Mental health needs may be ignored or misunderstood in most churches within South Asia because of theological/cultural differences. Inspired by greater awareness, leaders can directly confront the stigma and try to normalize the discussion of mental well-being and ensure that the church does not hide people seeking assistance behind the idea of sinfulness.

Suggested Curriculum and Topics for Pastoral Training

A well-designed curriculum provides pastors and church leaders with the knowledge, skills, and confidence to effectively address mental health concerns. In the South Asian church, such training must close the gap between theological doctrines and culturally contextual practices. Pastors can be assured that they will thoughtfully, ethically, and educationally respond by going over typical mental health issues, crises, and referral and feedback mechanisms. The following are three elements that must be present in any pastoral training program.

[29] Young Shim, Rebecca Eaker, and Junkoo Park, "Mental Health Education, Awareness and Stigma Regarding Mental Illness among College Students," *Journal of Mental Health & Clinical Psychology* 6, no. 2 (August 24, 2022), https://doi.org/10.29245/2578-2959/2022/2.1258.

[30] Parinaz Khalili Khouzani et al., "Identifying the Key Components of Providing Spiritual Care in the Hospital: A Scoping Review Study," *BMC Palliative Care* 24, no. 1 (May 22, 2025), https://doi.org/10.1186/s12904-025-01762-x.

1. Basics of Mental Health (Anxiety, Depression, Trauma)

Pastors must understand the foundational concepts of mental health, including the symptoms, causes, and impact of common conditions such as anxiety, depression, and trauma. This knowledge teaches them early warning signs, how to support individuals with their morale and spiritual needs, and when to refer them to a professional.[31] During the training, the participant should be made aware of how these conditions vary across cultures, specifically in South Asian communities where talking about the conditions is stigmatized. By making pastors aware of this, they will be able to instill an atmosphere and support that makes people aware of mental problems without having to stigmatize the person and help them find help through professional and spiritual support.

2. Suicide Prevention

Suicide is a critical issue that pastoral leaders must be prepared to address with urgency and sensitivity. The training should be done on the identification of warning signs, which would include withdrawal, hopelessness, sudden mood changes, or expressions of wanting to die. Pastors are advised to be trained on how to carry out compassionate and non-judgmental discussions, assess the levels of risk, and take necessary guarding measures on the spot.[32] These are local emergency resources, crisis hotline information, and professional contacts. Within churches in South Asia, it is important to overcome cultural stigma that may lead to the families concealing suicide.

[31] Judy Leung and Kin-Kit Li, "Faith-Based Spiritual Intervention for Persons with Depression: Preliminary Evidence from a Pilot Study," *Healthcare* 11, no. 15 (July 26, 2023): 2134–34, https://doi.org/10.3390/healthcare11152134.

[32] Ashley Marie Herron, "The Heart of the Matter: Prioritizing the Mental & Emotional Wellbeing of Pastoral Leaders," PhD diss., Lynchburg, VA: Liberty University, 2024.

Education on suicide prevention trains the pastors to act at an early stage, which could save lives and lend hope.

3. Referral Practices and Professional Boundaries

Pastors are not mental health professionals, and part of effective ministry is knowing when and how to refer individuals to qualified counselors, psychologists, or psychiatrists. Referral practice training helps pastors learn how to detect when they are out of their depth concerning a situation and how to direct a congregant to the proper resources without losing trust and confidentiality.[33] Clarity on professional boundaries avoids burnout, safeguards ethical care, and safeguards the pastor and the care seeker. In the case of the South Asian churches, this implies building a system of culturally competent practitioners aware of the community's specific needs and can assist in follow-up care in agreement with the church's leaders.

Workshops, Seminars, Continuing Education, and Partnerships

Workshops and seminars provide pastors and church leaders with practical, interactive learning opportunities to engage with mental health topics. Mental health professionals, such as pastoral care experts or other church-based counseling organizations, may facilitate these. Lifelong learning helps leaders remain current with the new research and treatment techniques and cultural trends that affect mental health. Partnerships are also very important; working with local clinics, counseling, and

[33] Morgan R. C. McCain, "A Grounded Theory Exploration of Clergy's Counseling Referral Practices in Black Churches," PhD Diss., Lincoln, NB: University of Nebraska-Lincoln, 2016.

community organizations helps to bridge the gap between church-based spiritual care and professional psychological care.[34] South Asian churches find it important to have partnerships to work with culturally competent counselors because it helps to eliminate linguistic and cultural barriers. One of the ways that training can be incorporated into the church is by regularly holding special training sessions, like a yearly mental health awareness weekend or quarterly leadership training retreats. This continued investment indicates that it is not a short-term program but is about mental health.

The Role of Theological Seminaries in Offering Mental Health Components

Theological seminaries are pivotal in shaping the next generation of church leaders, making them a key setting for integrating mental health education. Most pastoral training programs today are already characterized by emphasis on biblical studies, preaching, and church administration, but not much on mental and emotional wellness. Introducing classes on counseling skills, crisis intervention, and mental health first aid allows future pastors to be ready to respond to mentions of human suffering in all of its manifestations.[35] In the South Asian context, seminaries can also design specific courses that work on cultural stigma, gender, and the theological misconceptions that are prevalent against mental health care. Introducing mental health education into the theological curriculum, seminaries send a poignant signal that spiritual health is a

[34] Philip Rawlings, "The Highwayman's Case: Fact or Fiction?" *SSRN Electronic Journal*, 2022, https://doi.org/10.2139/ssrn.4056448.

[35] Gideon Ngi Nganyu, "Theological and Psychological Integration in Christian Psychotherapy: A Critical Review of the Literature and Implications for Church-based Practice," *Greener Journal of Social Sciences* 15, no. 1 (January 31, 2025): 75–82, https://doi.org/10.15580/gjss.2025.1.022525031.

religious and clerical duty. Graduates will be in a better position to develop churches that are emotionally healthy and alive.

Building Church-Based Support Systems

In this section, I focus on the need to equip pastors and church leaders in South Asian congregations with the tools and knowledge required to address mental health responsibly and effectively. While these leaders are deeply respected for their spiritual authority, many lack the training necessary to recognize or respond to mental health challenges. Developing competence in this area ensures that they can provide both biblical care and appropriate referrals when professional help is needed. By outlining strategies such as building mental health awareness, creating structured training programs, hosting workshops and seminars, fostering partnerships, and integrating mental health education into theological seminaries, I demonstrate how pastoral leaders can be empowered to serve their congregations with wisdom, compassion, and cultural sensitivity.

Small Groups and Lay Counseling Models

Small groups offer an intimate setting where congregants can share openly without fear of judgment. In the South Asian church, these groups might be structured around particular needs-grief support, parenting, stress management, and so on, and by trained lay counselors. The lay counseling models provide ordinary church people with minimal tools of listening, empathy, and indications on when to hand over a case to a

professional.[36] This strategy is effective since members relate to peers better than clergy. Small groups provide safe spaces for vulnerability in South Asia, where hierarchy can sometimes lead people to withhold vulnerability. Small groups support a regular meeting, nondisclosure contracts, and pastoral care, which regularize mental health topics and provide spiritual and effective support. They also provide steady follow-ups that the pastors might not have time to give.

Mental Health Ministry Teams

A mental health ministry team is a dedicated group within the church trained to provide education, resources, and first-response care for mental health concerns. This team may consist of lay people, medical practitioners within the church, and pastors who may have received mental health training.[37] Their activities include conducting awareness events, workshops, a resource directory of available counselors in the area and providing a first response to a crisis. A visible team can help the church in the South Asian context because a strong demonstration of the explicit importance given to mental health care is an acknowledgement and a recognition of its part. It also becomes simpler for the congregants to understand where to get assistance. In collaboration with the pastoral leadership, the ministry team can root the church in the theological values, meeting them

[36] Stella D. Potgieter, "Communities: Development of Church-Based Counselling Teams," *HTS Teologiese Studies / Theological Studies* 71, no. 2 (February 6, 2015), https://doi.org/10.4102/hts.v71i2.2050.

[37] Ayanna Wells et al., "Engaging Faith-Based Organizations to Promote Health through Health Ministries in Washington, DC," *Journal of Religion and Health*, September 10, 2022, https://doi.org/10.1007/s10943-022-01651-0.

with evidence-based, compassionate mental health interactions. This organization also disperses accountability so that there is no sole charge of mental health care on the pastor.

Creating Peer Support and Prayer Groups

Peer support and prayer groups combine emotional care with spiritual encouragement. These groups attempt to match people with similar experiences together—people who are healing after depression, anxiety, or trauma—so they can walk in understanding. The prayer component ensures that members have a spiritual background, so they get some comfort and strength in the presence of God. Unlike strictly spiritual groups, however, these groups also deal with emotional health and practical coping options.[38] In South Asian churches where spiritual solutions are carried to such an extent that psychological care is overlooked, such groups can model and harmonize the two. Professionally trained facilitators help to keep discussions on track, respectful, confidential, and growth-oriented instead of gossipy or judgmental. Gradually, peer and prayer groups can help to remove stigma as people realize that mental health is a part of the human condition, and the issue can be discussed in a religious community, and that people can indeed share their stories in a participating congregation.

Empowering Congregants to Support Each Other

Building a supportive church culture requires empowering members to recognize

[38] Ana Patrícia Tavares et al., "Spiritual Comfort, Spiritual Support, and Spiritual Care: A Simultaneous Concept Analysis," *Nursing Forum* 57, no. 6 (November 30, 2022), https://doi.org/10.1111/nuf.12845.

and respond to one another's emotional needs. This starts with training congregants on the basics of mental health awareness, warning signs to be alert to, proper listening skills to display, and supporting professional help when needed.[39] In South Asian communities, where extended family models are valued, this training is culturally relevant since mutual care and support are important. It also contributes to overcoming the tendency to neglect (disregard) or conceal mental health problems as a result of stigma. By nonjudgmentally encouraging what is called the "see something, say something" principle, churches can win the hearts of individuals who feel that no one is invisible. Once the church members know their role in mental well-being, the church can become a support network instead of a network of suffering.

Using Testimonies to Break Stigma

Personal testimonies are a powerful way to challenge misconceptions and normalize conversations about mental health. When ministry leaders whom the congregation recognizes as credible speak out about their depression, anxiety, or other treatment, it has a clear message: mental health care and faith can be compatible.[40] In South Asian churches where reputation (*izzat*) commonly motivates individuals to conceal their oppositions, listening to testimonies of strength can empower people to seek assistance without any form of disgrace. When testimonies are shared, this can be done in

[39] Matthew Brown, "Church and Community: Bridging the Gap to Create a Culture of Acceptance and Inclusiveness," DMIN Diss., Lynchburg, VA: Liberty University, 2024, https://digitalcommons.liberty.edu/cgi/viewcontent.cgi?article=6412&context=doctoral.

[40] Heather Stuart, "Reducing the Stigma of Mental Illness," *Global Mental Health* 3, no. 17 (May 10, 2016), https://doi.org/10.1017/gmh.2016.11.

sermons, small groups, or special awareness sessions. Care must ensure that such stories are told between consenting people without crossing their boundaries. In the long run, introducing testimonies in church life can help shift the discourse from being unable to talk and being judged to an open discussion about being open and caring.

Partnerships and Referrals

In this section, I focus on the critical role of partnerships and referrals in building an effective and sustainable mental health ministry within South Asian churches. While pastors and church leaders provide vital spiritual guidance and community support, they cannot fully address the complexities of mental health on their own. Collaborating with mental health professionals, social workers, and community organizations ensures that congregants receive holistic care that honors both their faith and their psychological needs. Developing clear referral pathways, fostering trust with culturally competent providers, and grounding partnerships in ethical and theological principles creates a bridge between spiritual care and clinical expertise. By integrating these collaborations into the life of the church, congregations can move from isolation to inclusion, ensuring that members struggling with mental health challenges receive timely, compassionate, and comprehensive support.

Collaborating with Mental Health Professionals and Community Resources

Partnerships with mental health professionals enable churches to extend their care beyond spiritual support to specialized clinical assistance. In North America, the pastoral care approaches of South Asian congregations can also be complemented with

professional treatment services, preventing the development of long-term consequences of suffering. Collaboration may be in the form of inviting psychologists or psychiatrists to conduct church talks, co-facilitating learning sessions, or referrals of congregants to professionals whom they can trust.[41] Congregations can also collaborate with community agencies that provide free or reduced-fee mental health care, which benefits congregants without insurance coverage. Pastors and mental health specialists can offer holistic services through collaboration to help people in spiritual, emotional, and psychological health.[42] This alliance also reminds members that there is nothing to feel ashamed of in seeking professional help, and neither does it mean one is showing weakness but is being prudent and investing in one's health.

Creating a Pastoral Referral System

A structured pastoral referral system ensures that when congregants present with signs of mental distress, there is a clear and respectful pathway to professional help. Such a system could comprise an initial pastoral evaluation, confidential record-keeping, and a list of vetted mental health resources.[43] This must be openly and sensitively done, where the congregant feels it is an act of support, not a pass-off. With personal relationships hugely cherished in the South Asian churches, the issue of referral should be made understandable by the pastors as an extension of care and not as an alternative to spiritual

[41] Lilian G Perez et al., "Partnerships between Faith Communities and the Mental Health Sector: A Scoping Review," *Psychiatric Services* 76, no. 1 (October 2, 2024), https://doi.org/10.1176/appi.ps.20240077.

[42] Ibid.

[43] Swihart et al., "Cultural Religious Competence in Clinical Practice."

counseling. Connection with the pastor after referral can assist the members in remaining connected to the church while they undergo professional treatment.[44] An effective referral system also helps pastors avoid working beyond their expertise without jeopardizing their moral obligation to offer suitable services.

Role of Social Workers, Counselors, and Therapists

Social workers, counselors, and therapists bring specialized skills complementing pastoral care and support. Social workers would assist in linking congregants to various resources, including housing, employment, and financial aid, which are likely to impact their mental health.[45] Licensed counselors and therapists present programs to deal with depression, anxiety, trauma, and family issues. Culturally sensitive professionals are particularly helpful in the context of general South Asian churches, where cultural stigma, family dynamics, and religious beliefs constitute the cornerstones of the help-seeking process. The pastors can also work hand in hand with such professionals through co-counseling, joint workshops, or consultation visits to each other on complicated cases (with the implied consent of the congregant).[46] This combination of disciplines ensures that members get the emotional and practical support they need and that pastors are part of the journey with them in the healing process.

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[44] Ibid.

[45] Ari Sytner, "Social Work and Pastoral Counseling: Empowering Each Other," *Journal of Religion & Spirituality in Social Work: Social Thought* 37, no. 2 (January 24, 2018): 202–19, https://doi.org/10.1080/15426432.2017.1422416.

[46] Ibid.

Building Relationships with Culturally Competent Providers

Cultural competence is essential when choosing mental health partners for South Asian congregations. Cultural values like family honor, interdependence, and religious traditions lie within the reasoning of South Asians, who understand that those who understand all these are in a good position to engender trust and deliver quality care. Churches can keep a list of providers who can be regularly updated with suggestions from members who have used their services. These relationships may be achieved through a meeting with local mental health professionals, a cross-cultural training session, or inviting them to the church event and creating an acquaintance. The church can serve as a medium of culturally knowledgeable care and not an obstruction. Good associations with culturally competent providers also help ensure congregants are not hesitant to honor their referrals because they do not have to clarify and defend their cultural orientation to them.

Ethical and Theological Considerations in Partnerships

While partnerships with mental health professionals are valuable, they must be guided by ethical and theological principles. Informed consent, confidentiality, and autonomy are the prerequisites of working with the congregant. Pastors should also see to it that any joint effort does not undermine the main theological teachings of the church and is open-minded to scientific and medical views. In South Asian contexts, Pentecostal/charismatic, such a balance is critical, as there should be firm belief in the healing power of God, balanced against an awareness of how medical and psychological

treatment can be applied. One way to think theologically about partnerships is as furtherance of God's common grace, acknowledging the gifts of professional skills and professional knowledge to be deployed to the betterment of the community. When pastors go into partnerships humbly and without confusion, they can demonstrate the interplay between faith and professional expertise in leading to the holistic healing of the people of God.

Preaching, Worship, and Liturgy as Healing Tools

In this section, I focus on the importance of building strong partnerships and referral systems that connect South Asian churches with mental health professionals and community resources. While pastors and leaders provide vital spiritual support, many mental health concerns require specialized care that goes beyond the scope of pastoral counseling. By establishing trusted collaborations with counselors, therapists, social workers, and culturally competent providers, churches can create a holistic model of care that respects both faith and science. At the same time, ethical and theological considerations must guide these partnerships so that they remain rooted in biblical principles while valuing professional expertise. Through intentional relationships, clear referral systems, and ongoing collaboration, churches can extend their ministry into spaces of healing that many congregants would otherwise never access.

Preaching that Addresses Mental Health, Suffering, and Hope

Preaching is one of the most potent tools pastors have to shape the attitudes and beliefs of their congregation. In South Asian churches where there is a negative attitude

to mental health, sermons can be utilized to debunk negative beliefs and provide biblical information to promote the worth and dignity of individuals with mental illness. Pastors can freely explore biblical characters who struggled with emotional health, such as the despair of Elijah (1 Kgs 19) or the laments of David in the Psalms, to demonstrate that this happens to all humans. When they address mental health in the pulpit, pastors normalize the discussion and destigmatize the issue of shame that often remains a part of mental health. Such messages that remind one how God is present in the middle of suffering, bringing forth God's compassion and teaching one to seek assistance, can alter the congregation's attitude. Preaching must highlight aspects of hope, such as that healing can be attained through prayer and a professional's aid. Through modeling openness, pastors admit others to speak up and seek care, offering a culture in which mental health issues are addressed not with disrespect but understanding.

Incorporating Lament, Healing, and Restoration into Worship

Worship services offer unique opportunities for emotional expression and healing. Including biblical lament within the liturgy gives congregants a place to grieve, feel pain, express frustration, and be safe regarding God.[47] This may be by particular songs, prayers, or Scripture readings that mention or refer to suffering whilst looking ahead to the hope that God offers restoration. There are opportunities to incorporate healing prayers and anointing services into worship, giving a time to affirm individuals publicly

[47] June Dickie, "Practising Healthy Theology in the Local Church," *STJ | Stellenbosch Theological Journal* 7, no. 1, June 29, 2021, https://doi.org/10.17570/stj.2021.v7n1.a02.

and spiritually bless them. Worship leaders benefit from picking music that represents the struggle and the hope in Christ to have a balanced emotional trajectory throughout the service. In South Asian churches, public vulnerability may be culturally awkward; however, formal opportunities to lament as a community can give formal authority to vulnerability. The themes of restoration may also be emphasized using communion, testimonies of restoration, or responsive readings, which declare the power of God to renew the mind and spirit.[48] This assimilation renders worship a venue of praise and refuge to the downcast.

Using Scripture and Testimony to Shape a Supportive Culture

Scripture provides a robust foundation for challenging stigma and promoting compassion toward those with mental health struggles. Scripturally supported prayers about the closeness of God to the brokenhearted (Ps 34:18), God's admonition to bear another man or woman (Gal 6:2), and God's invitation of rest to the weary (Mt 11:28) can be added to sermons, prayers, and Bible studies. Testimonies of congregants who have struggled with mental health issues and received support (both spiritual and secular) can prove a good point to make. Told without coercion, these stories provide hope to others and show that there is a way that faith and treatment can complement each other. Testimonies can also shatter the silence imposed by stigma in South Asian contexts and demonstrate that there is nothing negative about seeking help in terms of faith. Testimony and Scripture played a role in making a culture in a church where its members feel

[48] Ibid.

comfortable sharing their truth, seeking support, and giving it. In the long run, this can turn the congregation into a community of kindness and compassion.

Special Services: Mental Health Awareness Sundays, Healing Services, etc.

Special services dedicated to mental health awareness can strongly state the church's commitment to holistic care. Mental Health Awareness Sundays may incorporate guest speakers, such as Christian counselors or psychiatrists, who inform the congregation about mental well-being regarding faith. Prayer is a healing service that centers on reconciliation and restoration on an emotional and mental level and incorporates worship, Scripture, and professional knowledge, which can help to achieve a spiritual and emotional state. These services can also lead to opportunities for resource distribution, including counseling referrals, mental health literature, or hotline crisis information. In South Asian churches, such incidents have the potential to enhance understanding of the boundaries between conventional spiritual care and professional psychosocial support. They can alleviate members' concerns by ensuring both are legitimate and useful means of care. Alternative topics include emotional health-based retreats, mental health resilience youth initiatives, and women's conferences that discuss the connection between mental health and faith. Integrating mental illness awareness into the rhythm of church life allows special services to socialize care-seeking behavior and show that the church is a safe and proactive healing place.

Measuring Impact and Pastoral Effectiveness

In this section, I focus on how churches can evaluate whether their mental health ministry is effective. Measuring impact involves both numbers, such as attendance and referrals, and stories, such as testimonies and feedback. By combining these methods, pastors and leaders can see if stigma is decreasing, if people are seeking more help, and if leaders are growing in confidence. Ongoing mentorship and reflection also ensure that pastors continue to improve and respond with care over time.

Developing Qualitative and Quantitative Tools to Assess Effectiveness

Measuring the impact of the mental health ministry requires both qualitative and quantitative methods. Some quantitative instruments may include attendance records in mental health workshops, the number of referrals made to mental health professionals, and surveys on attitude change towards mental illness. Such surveys may also be used anonymously before and after ministry services are implemented, which can provide information on changes in stigma, awareness, and desire to seek assistance. Qualitative research, like in-depth interviews, focus groups, and open feedback, allows pastors and ministry leaders to experience personal experiences and stories that cannot be captured in numbers. In the case of South Asian churches, the measures need to be culturally sensitive and reflective in terms of relevant languages to erase doubts on the part of members to engage in the measures. Combining data-related and more personal accounts

allows for taking the ministry development as a whole.[49] This method also aids in determining areas that may require increased training, improvement, communication, or program modification in the future to maintain persistent similar improvements.

Feedback from Congregants and Leaders

Direct feedback from congregants and church leaders is essential for assessing pastoral effectiveness in addressing mental health. This feedback can be obtained during frequent check-ups, anonymously through surveys, or in open forums, whereby members' experiences are not subject to judgment or punishment. Congregants can report on how sermons, workshops, and/or pastoral counseling have assisted them in their understanding of mental health problems or motivated them to seek assistance.[50] Leaders can provide insights into whether pastoral training has made a difference in their response to mental health priorities with appropriate responses. In South Asian churches, anonymous feedback collection is necessary since stigma might affect their candidness. An invitation to give honest and constructive feedback also sends a message to the congregants that what they say is important in shaping the ministry practice. This leaves a feeling of mutual responsibility and builds trust between the church leadership and the members, leaving a healthier atmosphere to implement continued mental health care.

[49] Robert B. McKenna and Katrina Eckard, "Evaluating Pastoral Effectiveness: To Measure or Not to Measure," *Pastoral Psychology* 58, no. 3 (March 17, 2009): 303–13, https://doi.org/10.1007/s11089-008-0191-5.

[50] Ibid.

Indicators of Stigma Reduction and Increased Help-Seeking

Churches can track specific behavioral and attitudinal indicators to measure whether stigma is decreasing, and help-seeking is increasing. For example, a leader can check whether the number of congregants discussing mental health in small groups is growing, whether people are discussing personal stories of mental health recovery more frequently, or whether the congregants are attending mental health education events. A further indicator is that the number of pastoral referrals to mental health professionals is also increasing, indicating that leaders are beginning to appreciate the role of professional intervention. Another way South Asian churches can partner with local counselors or clinics is to collect anonymized information on whether or not church members are utilizing their services. Ultimately, such indicators can tell whether barriers to the relationship between cultures are broken and whether congregants feel more assured of seeking help. Small changes, however, are significant indicators that one's church's mental health ministry is having an impact, including less negative talk about the mentally ill and more compassion in discussing mental illness.

Ongoing Mentorship and Reflection for Pastors

Pastoral effectiveness is not a one-time achievement but a continuous process of growth and reflection. Continuing mentorship programs should include less experienced pastors with those who have developed successful mental health ministries, so they can give guidance and practical advice to support their development. Reflection may occur during periodic peer meetings when pastors share real-life situations, difficulties, and victories. Through such meetings, leaders can interact freely, learn how each other

operates, and modify their practices to suit their congregations. Pastors may also take personal journals or attend spiritual direction to process their emotional well-being and spiritual robustness.[51] South Asian church leaders find mentorship very useful since it helps individuals overcome isolation that may come along with practicing pastoral work, especially when addressing culturally sensitive issues like mental health. Lifelong learning and accountability help pastors have relevance, compassion, and responses in the long-term perspectives of their care measures.

Summary

In this chapter, I addressed a more functional approach to bridging the theological frameworks discussed in chapter 3 to adaptation of practical approaches to mental health concerns in South Asian Pentecostal/charismatic churches in North America. I reviewed existing models of pastoral care, the inadequacies of mental health literacy, stigma, and poor liaison with professionals, and put forward a new model that involves theology, empathy, and bonding with the professional to fill in the gaps. The strategies incorporate the training of pastors, establishing church support mechanisms, partnerships, preaching, worship, and testimonies to end stigma. I also debated measuring impact through qualitative and quantitative instruments, feedback, and mentorship. These practices create the structure of a compassionate and informed ministry that I build on further in chapter 5 by providing the steps to the implementation, evaluation, and long-term sustainability.

[51] McKenna and Eckard, "Evaluating Pastoral Effectiveness," 303–13.

Part Three

Ministry Strategy

Chapter 5

Implementation and Assessment

In this chapter, I aim to transition from the theological and practical bases laid out in the previous chapters to a pragmatic action plan to achieve a mental health ministry in South Asian Pentecostal and charismatic churches in North America. Although in earlier chapters I discussed the theological vision, cultural realities, and ministry practices required to meet mental health needs, I am concerned in this chapter with the ways those concepts can be translated into concrete, measurable projects. The implementation ensures that the ideas discussed are not taken to the point of theory but are implemented in a manner that has practical value for congregants. The tests would equip one with an instrument to determine whether such initiatives are working and whether they contribute to significant changes in attitudes, behaviors, and outcomes of mental health. Together, implementation and assessment form the bridge between vision and sustainable transformation.

I link in this chapter ministry practice to actionable steps by outlining a clear framework for introducing mental health initiatives in church life. The what and why are found in ministry practice as such, but implementation establishes how and when. As an example, it is a valuable objective to train pastors to identify depression indicators. Nevertheless, unless there is an organized strategy to deliver this training, resources, and follow-up, the goal might not be achieved. Equally, to promote open dialogue around mental health needs more than words, it involves providing safe environments, educating

facilitators, and arranging regular meetings with the aim of promoting a conducive environment. In this chapter, I help churches work forward strategically and purposefully by dividing these goals into small, manageable steps.

Assessment is necessary for long-term impact because it allows leaders to determine whether their efforts are making a difference. Lack of assessment makes it unclear whether or not stigma is declining, whether more individuals are seeking help, and whether pastors feel more prepared to respond to mental health needs. Results assessment can also be a form of accountability, with the church members, leaders, and collaborating organizations able to be confident that the resources are being used effectively. Furthermore, the assessment identifies some areas that should be improved; thus, corrections can be made to strengthen the ministry in the long term. It changes the way ministry is being performed, so that it is actually producing the fruit that it is supposed to produce. This assessment could also be applicable in the determination of the correctness of the stance of the ministry as to whether it is a culturally sensitive and biblically based enterprise, especially in the South Asian churches, whereby culture and theology could have a persuasive aspect in the formation of the perception of mental health.

This chapter is divided into a logical flow. I start with an implementation framework that involves the steps to develop a mental health ministry within a local church context. I accompany this with a training rollout strategy that I apply to determine the way pastors and leaders are trained. In the second section I entail the establishment of partnerships and support networks that allow the churches to be connected with mental health professionals and community resources. Contact with qualitative and quantitative

evaluation strategies is considered in the following section to evaluate the efficiency of the ministry. The notion of continuous improvement and the use of feedback to enhance approaches is also addressed, and a case study of pilot implementation is provided to illustrate how this happens. Lastly, there is a conclusion and theological reflection at the end of the chapter that ties the practical work back to the biblical and theological principles that guide this dissertation.

Implementation Framework

In this section, I lay out the practical steps for introducing a mental health ministry in South Asian churches. The goal is to move from vision to action by providing a structured plan that church leaders can follow. This framework outlines the stages of implementation, the roles and responsibilities of pastors, elders, lay members, and mental health professionals, and the resources needed for success. It also considers cultural and theological factors that shape how ministry is received in South Asian contexts. By offering a step-by-step guide, this section ensures that the vision for holistic care becomes a sustainable and effective part of church life.

Step-by-Step Plan for Introducing Mental Health Ministry in South Asian Churches

The most crucial and important process involved in the establishment of a mental health ministry is the establishment of commitment and understanding of top decision-makers in the church, senior pastors/elders. This commences with a clear presentation of the vision, how mental health care is closely related to the mission of the church, and holistic pastoral care. With the biblical basics and the theological knowledge discovered

in chapter 3, leaders are shown that mental health care does not exist in isolation from spiritual care but is an essential component of shepherding the people of God. It is beneficial to introduce some evidence related to the situation in South Asia, specifically, the stigma, the absence of awareness, and insufficient use of mental health services, which contribute to proving the urgency and relevance of this ministry. Leadership buy-in ensures that the initiative is supported by the pulpit and incorporated into the overall life of the congregation.

Once leadership is on board, the next step is to form a dedicated mental health ministry team. This team must include pastoral employees, trained lay leaders, and employees who may have professional training in counseling, psychology, or social work. This diversity means that there are a theological foundation, cultural sensitivity, and professionalism on the table with a team. This team includes the design, implementation, and management of the mental health services of the church and secure its spiritual and clinical competencies. Transparency and reduced obstacles to help-seeking by congregants are further encouraged due to the trusting team members.

To make the ministry effective, there must be sufficient training of pastors, elders, and lay leaders in mental health literacy. This entails awareness of the common mental health issues, such as depression and anxiety, and quite achievable skills such as suicide prevention, confidentiality, and making appropriate referrals. The past theological misunderstandings and stigma contained in earlier chapters should also be addressed through training. Continued training of the leaders with seminars, workshops, and partnership with the other mental health organizations ensure that the leaders are well acquainted with the best practices and can respond to the evolving needs with a shift in

their style of operation. Such training helps leaders feel more confident and become more qualified to offer spiritual and practical support.

It is prudent to start with pilot programs before rolling out the ministry on a large scale. They can be local projects, such as making the same one Sunday a month to do mental awareness work or to create a support group meeting where individuals can talk about stress and anxiety problems or grief. The advantage of small-scale is that it allows the ministry team to receive the feedback, identify what is effective, and work to fix it before it grows. Pilot programs can also be used to test cultural adaptation to ensure that the ministry is very appealing to the South Asian context and fulfils the population's needs.

The ultimate goal is for mental health awareness and care to become a natural part of church life. This entails the incorporation of mental health issues in preaching, Bible study, youth ministry, women's fellowship, and prayer meetings. Member testimonies about how members have sought and been helped may be made to normalize the discussion and make more people seek help without feeling ashamed or humiliated. Through association with the central concern of spiritual growth, the church projects that the spiritual, emotional, and psychological well-being is equally essential as spiritual development.

Finally, the ministry should be evaluated at all levels to determine whether it is fulfilling its goals. Through surveys, interviews, and pastoral reflections, one can assess effectiveness, what strengths the ministry possesses, what areas to improve, what values, and areas of weakness. The congregant comments also help the team to make the programs more culturally sensitive, theologically sound, and accessible. This perpetual

checking and fine-tuning keep the ministry up to date, responsive, and viable in the long term.

Roles and Responsibilities

Pastors are at the center of the leadership of the mental health ministry, and they must provide pastoral care and spiritual support to congregants. They are invited to preach and biblically teach about mental health so the congregation can know that emotional health is one of the things God wants human beings to have to be complete.[1] Concurrently, pastors should not feel tempted to override the need to offer spiritual solutions instead of professional mental health care, but they must understand the boundaries where they can intervene in the practice field of clinical practice. They must also be given the mandate to determine when the needs of a congregant are out of the care of the pastor by promptly referring the client to an appropriate mental health practitioner. The pastors are the role models of humility and ready to collaborate and thus, they form an environment of a culture that believes in a blend of faith and professional support in the church.

The elders and church leaders have a supportive and influential role in the implementation of mental health initiatives. They liaise with the pastor to ensure that such initiatives are popularized in the congregation and integrated into various church ministries. As supporters of the idea of inclusion, they actively aim to eliminate the

[1] Rabson Hove, "The Pastor as the Primary Teacher in the Church: The Meaning and Expectations of Pastoral Ministry within the Mainline Denominations," *Pharos Journal of Theology*, no. 104(5) (November 1, 2023), https://doi.org/10.46222/pharosjot.104.54.

stigma with their affirming language regarding the service of mental health and encourage discussion of the matter.[2] They also assist in the practical part of the ministry, such as budget, resource allocation, and log support, of the mental health ministry, which is there to work effectively. This is because they contribute to the ministry to make it valid and meaningful.

The lay members play a vital role in making mental health ministry a reality at the ground level. Their contribution can be rendered through volunteering in the support groups, prayer ministries, or the hospitality teams that make the environment welcoming to those who request assistance. Lay people can also encourage disclosure and beautify the action of help-seeking by telling their personal stories of their mental health. They also provide a spot to listen to, promote, and provide companionship to the isolated, otherwise known as peer support.[3] The reason for doing so is that they are actively engaged to the extent that the ministry is not just a top-down project, but an overall implementation adopted by and supported by the entire congregation.

Mental health professionals can also add the much-needed expertise and credibility to the ministry. Some of the roles they engage in are training the pastors, elders, and lay leaders on mental health-related issues, confidentiality, and good referrals. The church refers to them so that the congregants receive culturally competent care that

[2] Ibid.

[3] Jonathan T. Wall et al., "What about Lay Counselors' Experiences of Task-Shifting Mental Health Interventions? Example from a Family-Based Intervention in Kenya," *International Journal of Mental Health Systems* 14, no. 1 (February 20, 2020), https://doi.org/10.1186/s13033-020-00343-0.

does not require conforming to their faith and background.[4] Another aspect is that these professionals assist without collapsing the distance between clinical and theological knowledge, as they help group teaching resources to fit the South Asian context. They operate through collaboration to improve how the church can take care of its people in a holistic way.

Timeline for Rolling Out Initiatives

The following is a timeline for rolling out the initiatives. The timeline is divided into months.

1. Months 1–3: Vision Casting, Leadership Approval, and Team Recruitment

The first initiative articulates the vision of a mental health ministry with the church leadership; to be more precise, the pastor, elder, and every other critical decision maker. The role of this stage is to introduce theological, cultural, and practical justifications of the ministry, to gain their acceptance, and to recruit team members to join the mental health ministry. A combination of pastoral staff, lay leaders, and people who have an interest or experience in mental health care should be represented by team members.

2. Months 4–6: Team Training, Resource Gathering, and Partnership Development

After establishing the team, the next thing is to offer basic training on mental health awareness, cultural sensitivity, and referral processes. Educational resources like

[4] Edith K. Wakida et al., "Barriers and Facilitators to the Integration of Mental Health Services into Primary Health Care: A Systematic Review," *Systematic Reviews* 7, no. 1 (November 28, 2018), https://doi.org/10.1186/s13643-018-0882-7.

books, training manuals, and awareness campaigns should be collected or created. This step establishes formal partnerships with culturally competent local mental health practitioners, community organizations, and service providers to support the ministry reliably.

3. Months 7–9: Launch of Pilot Programs

During this period, the church has begun taking on small yet meaningful projects such as the Mental Health Awareness Sunday, where a monthly support group is formed and the use of information-specific post-service services. These pilot programs are a test run on how the ministry operates because the team will observe how the participants will interact, how things will work or fail to work, and how to streamline the process before it is implemented on a larger scale.

4. Months 10–12: Evaluation and Integration into Church Life

Upon completion of the pilot programs, the ministry team gathers comments on the feedback of the participants, the church leaders, and the mental health partners. This is modified based on this feedback to make the programs effective. Mental illnesses on this level are gradually factored into the familiar preaching, Bible studies, and youth ministries, among other ongoing activities in the church, so that they are absorbed within the church's culture.

5. Year 2 and Beyond: Expansion and Continuous Assessment

When the base is established, the ministry expands its programs and offers increasing support groups, education events, and cooperation with community organizations. The program measures the efficacy of the ministry in eradicating stigma and improving mental health literacy and confidence in an inclusive church environment

via ongoing annual assessment. Such reviews guide continuous improvements to ensure that the ministry can be practical and relevant.

Cultural and Theological Considerations During Implementation

Implementing the mental health ministry in the South Asian Pentecostal/charismatic churches entails a delicate balancing act between respecting the cultural values and bringing a healthier perspective towards mental wellbeing. Cultural values such as honor, integration into the family, and privacy must be respected. Nevertheless, the leaders are advised to make mental health issues open to individuals to reach out to them and reduce stigmatization. Theological communication should mention the established long-term South Asian Pentecostal/charismatic manifestations, the search for God's mercy, and the healing and justice as the core of care. It is important to emphasize that mental illness should be treated as part of holism (i.e., of holistic treatment that could not be discussed as containing spiritual negligence or sin). Moreover, there should also be diversity in South Asian communities, not to mention the language diversity, the caste and denominational diversity, among others. These must be addressed too, and programs must address these diverse settings. The ministry can be made biblically aligned and culturally sensitive by the sensitivity of culture and the richness of theology.

Mobilizing Resources

A mental health ministry requires financial planning and financial management. Churches ought to ensure that they put aside a small share of the annual budget to fund

other programs like training, workshops, and resource development. Other sources of funds may be obtained by appeal to Christian foundations, local health organizations or culturally specific bodies with particular emphasis on mental health outreach. Intended monies would also be generated through livelihood on specific services like the Mental Health Awareness Sundays. These resources help the ministry to continue with the program on a regular basis, pay the regular trainers, and distribute the materials so that the work can be sustainable and effective over the long term.

Well-trained highly motivated workers are needed in such an effective mental health ministry. The program should be given leadership, vision and theological basis by pastoral staff and elders. It can also be supported by use of volunteers who are like-minded leading small groups, hospitality events, and peer encouragement. This can be provided through mental health practitioners and professional counselors since they possess the necessary skills to administer specific treatment and train church leaders to administer specific training. These leadership qualities, participation laity, and facilitation of professional input will form a balanced and inclusive group that will serve the needs of its congregation.

A successful ministry is also characterized by practical assets. The learning resources must be printed in various South Asian languages so that people with other languages and generations can access them. There should be a special area in the church where the counseling sessions, small group meetings, and training workshops can take place, granting privacy and a feeling of safety. Also, workshops, awareness initiatives, and distance learning opportunities can be improved with the help of audio-visual tools, including projectors, sound systems, and web-based approaches. Such resources and

amenities facilitate the provision of professional, ordered, and culturally sensitive ministry work.

Training Rollout Plan

The pastor, elder, and lay leader training of the South Asian churches are in a blended format, a combination of face-to-face and online, so that it is accessible and continuous learning. Seminars take place quarterly in the central church venues or local meetings and involve the leadership of many congregations. The workshops are dedicated to the particular topics, which are anxiety, depression, recovery after trauma, and prevention of suicide, and include teaching, case studies, and role-play activities to gain trust in the face-to-face scenarios. These larger sessions are supported by monthly workshops, where the participants are provided with smaller, interactive settings in which they learn how to apply several skills, including active listening, crisis intervention, and effective referrals. Church leaders are invited to attend certified continuing education programs by seminaries or established mental health agencies to ensure the momentum. Some online resource hubs are also being developed, which hold lesson plans, articles and sermon outlines on the issue of mental health. To ensure the practical application of materials to the church setting, follow-up coaching/mentoring is applied.

The curriculum for this training integrates three essential areas that equip church leaders for effective pastoral care in mental health contexts. The initial one provides the basics of mental health, which include the most prevalent conditions, including depression, anxiety, and trauma, and teaches the leaders to recognize the signs and symptoms, know the risk factors, and value the effects of these conditions on both individuals and families. This entails culturally pertinent descriptions that identify with

the congregants of South Asians. The second area is suicide prevention, which educates pastors and leaders to recognize warning signs, have compassionate and non-judgmental conversations, and influence people to seek urgent help. Real-life measures are given to lead leaders in case of emergencies. The third area concerns referral practices and professional boundaries, which assist leaders in understanding when to refer a person to a mental health expert, confidentiality, collaboration with counselors and therapists, and remaining involved in spiritual care.

An essential component of the rollout is ensuring that trainers are culturally competent. The proposal involves the recruitment of South Asian Christian mental health professionals or persons with vast cross-cultural ministry knowledge who are familiar with the theological paradigm and the cultural values of the South Asian communities. These trainers are aware of such issues as family honor (*izzat*), stigma, and generational tensions, and can discuss these issues without losing the participants. They integrate Western mental health paradigms into the Pentecostal/charismatic worldview used in most South Asian churches such that it is not just be theologically correct but culturally attractive as well. Where applicable, training materials are translated into major South Asian languages, i.e., Hindi, Urdu, Punjabi, Tamil, and Bengali, to make them more accessible to leaders whose first language is not English.

Sustainability of the training program relies heavily on building strong partnerships with both theological seminaries and mental health institutions. Seminaries will be urged to incorporate mental health courses in their pastoral training programs and offer short courses or certificates in mental health ministry to pastors already in service. These seminaries may also use their facilities as places to hold large-scale training events.

Partnerships with mental health organizations will provide specific training programs and establish direct referral networks to church leaders, including hospitals, clinics, and counselling centers. Healthcare providers and faith leaders can be more incorporated since mental health professionals can be invited to discuss issues during church conferences and leadership retreats. The program also reaches out to faith-based and community networks already engaged in mental health activities, exchanges resources, co-hosts, and participates in educational efforts such as Mental Health Awareness Month or World Suicide Prevention Day.

The training rollout plan is suggested to accomplish more than abandoning the events concept, and to offer a lasting culture of learning, support, and collaboration within the South Asian churches. This integration of theological faith, applied competencies, and cultural competencies into the plan would help to ensure that pastors and leaders are in a better position to meet the mental health care needs of the members of their congregation, not to mention instilling a sense of trust and stigma reduction.

Building Partnerships and Support Networks

In this section, I focus on how partnerships and support networks strengthen the effectiveness of a mental health ministry in South Asian churches. While pastors and church leaders play a vital role, sustainable care requires collaboration with mental health professionals, other congregations, and community resources. By establishing formal agreements, mapping available resources, and developing referral systems, churches can move beyond isolated efforts to create a holistic network of care. Building these connections ensures that congregants receive both spiritual and professional support

while also reducing stigma and isolation. This section outlines how partnerships can provide accountability, broaden the scope of ministry, and foster long-term resilience in addressing mental health needs.

Developing a formal agreement with the mental health professionals is an essential step to be undertaken by the South Asian churches, and such an endeavor needs the capacity to provide holistic care. They are usually conducted in the form of memorandums of understanding (MOUs) in which they define the intensity of the partnership between the pastors and the mental health providers, referral procedures and confidentiality policies as points of contact. To illustrate, a local counseling facility may be interested in providing the referrals with lower-priced sessions, and afterwards, pastors could provide pastoral follow-up. Through the formal agreements, accountability is ensured, trust is established, and the congregants receive reasonable access to professional mental health services.

Churches can also collaborate to significantly increase their ministry capacity, especially for smaller groups that might not have the resources to start mental health programs on their own. Churches are able to better meet the requirements of mental health awareness by sharing training opportunities, events, and resources. For example, a community seminar on mental health could be co-sponsored by a network of South Asian Pentecostal churches. They could invite both members and non-members. Small congregations can also receive mentoring through larger congregations in terms of books, professional contact, models of ministry and integration, solidarity, and collectiveness in addressing the issue of stigma and cultural barriers.

Community resource mapping involves identifying and documenting available mental health resources within a geographic area. This entails culturally competent counselors, crisis hotlines, clinics, hospitals, and peer support groups. Churches can keep a current list of such resources, whether online or printed, in a list of available resources, including the languages spoken, specializations, and insurance coverage. An active approach assists pastors and leaders in recommending appropriate care to congregants within a relatively brief duration to reduce delays in seeking care and demonstrate the church's commitment to total well-being.

A sustainable referral system ensures that the congregants can easily transition between pastoral care and professional mental health care without feeling like they were discarded or criticized. This system should be confidential, plain, and adaptable to emergencies. In churches, there can be a special person called a care coordinator who can make follow-up referrals, follow up on congregants, and contact professionals. The concept of sustainability implies that the church should develop ongoing connections with the mental health providers, train the church leaders as much as possible on how referrals should be made, and have estimates regarding the feedback on whether the invigorating measures are effective. These systems can expand the pastoral scope of the church and provide an example of a multi-faceted, holistic system that cares about both spiritual and psychological well-being.

Assessment Strategies

In this section, I examine how South Asian churches can evaluate the impact and effectiveness of their mental health ministries. Implementation alone is not enough;

without proper assessment, it is difficult to know whether programs are reducing stigma, encouraging help-seeking, or strengthening pastoral confidence. Assessment strategies must use both quantitative and qualitative tools so that the numbers and the lived experiences together provide a full picture of ministry outcomes. Surveys, attendance records, and referral tracking can help capture measurable progress, while interviews and open feedback highlight personal stories and challenges. By assessing stigma reduction, changes in attitudes, and pastoral growth over time, churches can ensure that their ministries remain responsive, culturally relevant, and sustainable.

Surveys are one of the most accessible and measurable ways to assess the impact of mental health ministry within South Asian churches. They may be given pre-program and post-program to determine the changes in mental health knowledge, attitudes, and behaviors. There can be questions with Likert scale items to evaluate the level of comfort with the discussion of mental health, perceived stigma, or readiness to address a professional. Polling may also help determine the level of understanding of training content by pastors, leaders, and congregants. Anonymous feedback fosters honesty, particularly in cultures where stigma can be used as a deterrent to honesty. The online survey systems may be used due to the convenience of distribution and analysis of the data, and the paper survey is provided to older members and those who are not so tech-savvy. The findings help the leaders to make evidence-based choices to improve the ministry and focus on the areas that demand additional action.

Another quantitative evaluation tool that is quick and beneficial is attendance records. States of attendance at workshops, counseling, group meetings with peers, and events that help create consciousness on mental health should allow their leaders to note

attendance trends in the long term. Using the example of a gradual rise in the number of people attending mental health seminars may be a sign that the interest level has increased, and the level of stigma among the members has decreased. On the other hand, decreased attendance may suggest an issue with timing, cultural resistance, or a need for better outreach approaches. Attendance is also used to evaluate the ministry's reach and determine how many women, men, youth, and older people are engaged actively in the ministry. Attendance data comparison of various activities in the ministry can also aid the leaders in allocating resources in ways that would contribute to the most engaged programs. When used together with survey data, attendance records give a more comprehensive view of the numerical increase and the intensity of impact.

Interviews provide rich, in-depth insights into how individuals experience the church's mental health ministry. Interviews, which can take place in small focus groups or individually, enable the participants to express their personal stories, their views, and their feedback that surveys do not reveal. An example is having a congregant mention how a sermon on mental health has made them do counseling referrals, or a pastor mentioning how they have learned how to confidently make counseling referrals. Interviews can either be structured to include predetermined questions or semi-structured so that they provide a conversation range. To South Asian churches, interviews must be culturally sensitive and may be held in the languages that the participant prefers and in safe and confidential environments to foster openness. These interviews can be administered by pastors or other church leaders trained in active listening, although working with neutral third parties can produce more open feedback. Qualitative data

collected during the interviews can often expose subtle cultural processes, obstacles, and achievements that the quantitative data would have missed.

One of the most critical outcomes for any mental health ministry in South Asian churches is the reduction of stigma. The stigma measure implies the assessment of the change in language usage and willingness to discuss mental health. This may be considered depending on surveys, interviews, and even observations of interactions in the community. In an illustration, previously, there was no discussion of mental illness during the church meetings, and when the ministry is formed, church members emerge to discuss how they regained it, and that is a sign of progress. The change in attitude can also be evaluated by determining the rate at which the mental illness is talked about, discussed, and preached, and the character of the discussion and preaching on the positive nature. Reduction in the intensity of derogatory or dismissive words and usage of supporting words are indications of a cultural change. To assist the ministry in remaining on course, it would constantly track these changes over time to reinvest in the positive artistic and theological explanations of mental health.

Pastors are central in determining the way congregations react to mental health problems. There is a need to check on their confidence and competence over time as one of the ways of sustaining impact. This can be set by comparing self-evaluation pre- and post-training forms, peer evaluation, and congregant evaluation. Some of these evaluation areas would include how pastors can be aware of indications of mental health problems, recent pastoral counseling, appropriate referrals, and incorporating the mental health concerns in sermons. In addition, it is possible to estimate how comfortable they are working with mental health professionals. Another advantage to the pastors is the check-

ins, including yearly reviews or mentorships, which help them see the gaps and keep learning. With increased capacity and confidence regarding their role, pastors can be more open, reduce stigma, and shepherd the congregation to healthier mental health practices. Another guarantee of such tracking is accountability, as it signifies whether the gifts of training and resources bear fruit in the sense of real developmental leadership.

Continuous Improvement and Adaptation

In this section, I focus on how South Asian churches can sustain and strengthen their mental health ministries over time by embracing a culture of learning and adjustment. Ministry practice is never static; it must respond to feedback, cultural changes, and the evolving needs of congregants. Continuous improvement means carefully reviewing results, identifying gaps, and making necessary changes, while adaptation ensures that the church remains faithful to its theological convictions as it addresses mental health with compassion and wisdom. By incorporating congregational feedback, aligning ministry approaches with biblical principles, and updating strategies to remain culturally relevant, churches can build ministries that are both enduring and transformative.

A healthy mental health ministry needs to regularly evaluate its outcomes to achieve the purpose the ministry has set. It involves the analysis of the numerical data (surveys and attendance data) and the qualitative data (interviews and testimonies) obtained over the years. By comparing current outcomes to initial standards, leaders can identify the strengths and weaknesses of the design or implementation of the ministry. An example would be high attendance in awareness programs and low attendance in support

groups, which indicates failures in follow-up activities. Similarly, evaluations reveal that certain age groups or genders are underrepresented in ministry moments, meaning efforts must be enhanced to achieve better outreach. The leaders are expected to develop an annual review procedure during which the pastors, ministry teams, and mental health partners can freely and clearly discuss findings. These reviews can identify the gaps and praise the ministry's progress and importance to the congregants, which attracts more involvement and development.

Feedback should only be worth collecting when it results in actual transformation. Once some gaps and obstacles have been identified, the ministry leaders are left to cooperate and change their ways of doing things. To illustrate, when the congregants complain of the necessity to discuss mental health in mixed-gender groups, separate male and female sessions can be implemented. There might be a language barrier, and in such cases, the given materials might be translated into South Asian languages that are commonly spoken. Changes in style or topic of sermons, format of support groups, or quantity of training offered to leaders can also result from feedback. It is important to note that such changes should be communicated to the congregation in a way that directly shows that their voices are shaping the ministry. This builds confidence and promotes continued engagement. The ministry can be relevant, culturally sensitive, and practical by remaining responsive to constantly meeting the congregation's changing needs and breaking the existing barriers to mental health care.

As mental health awareness grows and new challenges emerge, churches must adapt without losing sight of their theological foundations. This includes assessing the relevance of new ministry programs, partnerships, or languages in terms of the church's

interpretation of Scripture, pastoral care, and cultural values. Individually, some examples are that when adopting updated psychological instruments or collaborating with secular practitioners, leaders must ensure that such practices do not oppose biblical teachings but complement them instead. Theological fit also demands that the learning about healing, suffering, and community responsibility always be manifested in the mental health programs. The church leaders can make the congregants accept change without fear that faith is being sacrificed by basing adaptations on the Scripture and sound theology. Such a mix of theological faithfulness and cultural responsiveness enhances trust, maintains pastoral credibility, and ensures that the ministry is a valid form of spiritual care and practical support to mental well-being.

Case Study of Pilot Implementation

In this section, I present a practical example of how a South Asian Pentecostal church in North America could adopt and implement a mental health ministry as a pilot program. A case study helps move beyond theory into lived experience, showing how vision, planning, and partnerships take shape within the life of a local congregation. By tracing the steps taken, the challenges faced, and the lessons learned, this example provides insight into how South Asian churches can balance cultural sensitivity, theological grounding, and professional collaboration. The outcomes and recommendations drawn from the case study highlight both the possibilities and the responsibilities that come with launching a mental health ministry. This framework offers a model for other churches considering similar initiatives.

Case Study of Pilot Implementation: Sanctuary Mental Health Ministries Model Adapted for a South Asian Pentecostal Church

The Sanctuary Course, created by Sanctuary Mental Health Ministries, is one of the most appropriate church-based mental health engagement models. This eight-week course provides the churches with the knowledge of how they can respond to the issue of mental health by teaching the principles of honoring biblical teaching, testimonies, and modern teachings. The course exists in the context of the religion and psychology, as it tries to help the church appreciate itself as a place where people feel free to discuss their mental health issues. The model solidly supports the South Asian leadership of the Pentecostal or charismatic churches in North America but needs contextualization. The perception and management of mental health involve the cultural perspectives of honor, respect of elders, collective decision making, and theological explanations of healing, which have a lot to unfold. The rationale behind piloting such a program in a South Asian church is to see whether the program can be effectively tailored to minimize stigma, build leaders, and provide long-term avenues to access professional support.

The following is the step-by-step implementation process of the case study pilot.

1. Leadership Buy-In and Cultural Adaptation

The first step is to gain full commitment from senior pastors, elders, and ministry leaders. South Asian contexts are largely top-down, and therefore, decisions need trusted leaders' support. Leaders screen the course deliverables, determine possible theological or cultural issues, and redesign discussion prompts or examples to capture the experience of living among South Asian immigrant families. Modifications might consist of handling

honour-shame interactions with stigma, incorporating South-Asian experiences, and interpreting main waste into a more culturally common language.

2. Formation of a Planning and Facilitation Team

A small group of facilitators is hired, preferably men and women, younger and older, to indicate the congregation's diversity. These facilitators receive brief and comprehensive training on course content, group facilitation skills, trauma-informed listening skills, confidentiality, and referrals. Trust and engagement are high because of the presence of facilitators who are already accepted within the community in South Asian churches.

3. Recruitment and Promotion

The program is communicated to the congregation through regular Sunday services and some methods of communication in the church, such as WhatsApp groups, newsletters, and ministry meetings. Pastors strategically position mental health as a discipleship and pastoral care problem, not merely a healthcare problem. Special invitations are offered to people who could be hesitant to go due to stigmatization.

4. Program Delivery

The eight weekly sessions include short video segments, Bible readings, personal testimonies, and guided discussions. Sessions are written to be interactive, and the participants are invited to express their thoughts in a respectful and confidential environment. Facilitators watch out when patients are emotionally distressed and address the agreed referral guidelines. Adaptations to culture can involve South Asian sayings, case histories in South Asian immigration life, and Scripture interpretations that can appeal to the theological paradigm of the congregation.

5. Follow-Up and Ongoing Support

After the program concludes, participants are invited to join smaller ongoing support groups or prayer gatherings. Facilitators help church leadership detect those who need extra support and refer them to culturally competent, qualified mental health practitioners they trust. Feedback surveys are being distributed to gauge perceived value, attitude changes, and willingness to seek help in the future.

Other churches' experience demonstrates that cultural context is one of the primary issues concerning completion. The material of the Sanctuary Course was written to engage the attention of a broad Christian audience. In this way, it might not sufficiently accommodate South Asian theological fallacies, issues with family relations that keep them tight-lipped, etc. The second obstacle is the scarcity of culturally competent therapists to whom the couple can refer, since not all mental health experts are knowledgeable about South Asian family structure and religious beliefs. Problems accompany play, and stigma arises. Others also take the initiative not to attend because the congregants will regard them as psychologically unfit to participate in and make the program appear to be a general discipleship and community care program rather than a mental illness program, and therefore an integral part of spiritual formation rather than a special treatment.

Churches that have implemented programs like the Sanctuary Course have reported a range of encouraging outcomes. Members developed greater awareness of mental health issues, including recognizing symptoms and understanding available resources. This increased knowledge has helped reduce stigma, making mental health discussions a normal part of biblical teaching and church life. Pastoral leaders gained

better competence, becoming more confident in identifying early warning signs and making appropriate referrals. Congregants also reported stronger community bonds, feeling less isolated and more supported by their church family. Additionally, many churches launched new ministries, such as Mental Health Awareness Sundays, peer support groups, and partnerships with local counseling services, ensuring ongoing support and integration of mental health care into church life.

Other religion-based immigrant interventions have followed the same patterns. For example, church community partnerships with communities such as the South Asian Mental Health Initiative and Network (SAMHIN) have demonstrated that bringing culturally relevant stories and resources into the lives of churches increases attendance. In the multi-ethnic cities, there are particular churches where the fairs related to mental health are organized, and professional counselors, social workers, and pastoral leaders coordinate and share the information and first analyses. This is because, through such initiatives, it has been established that faith groups are at the stage where cultural stigma to professional treatment occurs.

From this model, South Asian Pentecostal churches can learn several important lessons for shaping effective mental health ministries. First, cultural context matters deeply; teaching materials and discussions must acknowledge honor-shame dynamics, theological misunderstandings, and the stressors tied to immigration, ensuring relevance to the community's lived reality. Second, involving respected lay leaders helps normalize conversations around mental health, as their influence reduces stigma and builds trust. Third, strong relational systems with mental health professionals should be established before launching programs, preventing delays in care and ensuring smooth referrals.

Fourth, pulpit support is crucial, as when pastors openly endorse and preach about mental health, it gives credibility to the initiative and reduces stigma. Finally, ongoing support structures are vital; without sustained programs like support groups, counseling partnerships, and regular awareness events, the initial enthusiasm and impact of the ministry can quickly fade.

A practical pilot program for a South Asian Pentecostal church in North America could begin by running the Sanctuary Course as the main training program, while integrating South Asian testimonies and real-life examples to make it culturally relevant and relatable. A core team of facilitators should be formed, drawing from respected members across different age and gender groups to ensure inclusivity and representation. Partnerships with culturally competent professionals, such as South Asian Christian counselors and social workers, would strengthen the program by offering trusted expertise and culturally sensitive care. To support the initiative, funding can be secured through grants, denominational backing, and community donations, which would cover facilitator training, translation of materials, and guest speakers. Finally, the church should track the impact of the pilot using pre- and post-program surveys, attendance records, and participant interviews to measure change and effectiveness. The ultimate goal is not just reducing stigma but embedding mental health care into the daily pastoral life of the church for long-term sustainability.

Summary and Final Theological Reflection

The intervention and evaluation plan, as described in this chapter, was a comprehensive plan of integrating a sustainable and culturally sensitive mental health

ministry in the South Asian Pentecostal and charismatic churches in North America. Starting with a distinct goal, I connected theological beliefs in chapter 3 and ministry activities in chapter 4 to practical actions that could be traced via application in a real congregational context. The provided framework touched on the realities of the physical application of mental awareness and care delivery, which shows the significance of the dedication of the church leaders, adaptation of the application setting, and the participation of all strata of the church community.

The implementation process in stages included finding leadership buy-in, forming a facilitation team, developing a curriculum according to the local culture, and carefully selecting members. Particular emphasis was put on the complementary quality of theological integrity and mental health literacy, hence that both the spiritual and the mental health of the human being were understood within the ministry. The implementation plan of the training rollout ensured that pastors and leaders are trained in the core competencies in mental health and suicide prevention, professional boundaries, and referral practices, with the help of culturally competent trainers and in partnership with mental health facilities. It was fixed on establishing collaboration with professionals and community resources as a means of credibility and practical support.

Various assessment instruments to gauge the usefulness of the ministry were also given in the chapter. Quantitative measurement, such as surveys and attendance tracking, were mixed with qualitative measurement, such as in-depth interviews, to evaluate the alterations in a congregation's attitudes towards mental health. Focus was placed explicitly on measuring the change of stigma events, monitoring rising help-seeking behaviors, and measuring the pastoral confidence and competence over time. The

continuous improvement strategies were such that a feedback loop would be in place, and the ministry would be adaptive to the emerging needs without losing track of its theological direction. As discussed in the case study example given of a contextualized version of the Sanctuary Mental Health Ministries program, the opportunities and challenges of implementing such an initiative within a different setting, such as the South Asian immigrant church, made me see the resource. Cultural adaptation, involvement of respected leaders among the lay, pre-existing referral systems, pastoral endorsement, and regular follow-up were some of the lessons learned.

Theologically, the maintenance of mental health ministry in South Asian churches is not only a social or a medical issue but also a manifestation of the gospel message to love God and love neighbor (Mk 12:3031). It is an expression of the biblical request of wholeness whereby body, mind, and spirit are cohesive, being attended to by God. Regarding the ministry through the lenses of Pentecostal/charismatic, it is a belief system that acknowledges the role of the Holy Spirit as Comforter and Healer, yet it also states that in matters of professional psychological assistance, the ministry is in need. From a pastoral lens on theology, it reflects the role of the shepherd in leading, guarding, and diligently looking after the flock in all areas of life. Liberation theology calls the church to remove stigma and suppression that people living with mental illness experience and assert dignity as bearers of the image of God.

When I focus more on the findings of this dissertation, it is possible to observe the way the well-developed, theologically and culturally sensitive mental health ministry may open South Asian congregations toward communities of acceptance, support, and healing. The subject of the work has established pastoral care and the comprehensive

mission of the church as a spiritual formation method or object of help, emotional self-help, or practical support. Using mental health considerations of the dented fabric, the South Asian faith groups could be transformed into a place of refuge, in that the congregants would feel God and the expressive love of the people of God.

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