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The Response of the GMIM Golgota Bukit Ranomuut Permai Congregation to Mental Health Issues

Tanggapan Jemaat GMIM Golgota Bukit Ranomuut Permai Mengenai Isu Kesehatan Mental

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Abstract
This study aims to analyze the perceptions, attitudes, and responses of the congregation of GMIM Golgota Bukit Ranomuut Permai toward mental health issues, as well as to identify the theological, social, and cultural factors shaping those responses. Using a descriptive qualitative approach with purposive sampling techniques, the research involved 26 participants drawn from church ministers (Pelsus), youths, and general congregants, selected through an open online questionnaire. The data were analyzed thematically and validated through source triangulation. The findings indicate that 96.2% of respondents had previously heard about mental health issues, reflecting a high level of awareness. However, 65.4% reported having experienced stress, anxiety, or depression in recent months, even though access to professional services remains hindered by limited knowledge (12 mentions) and fear of social stigma (8 mentions). Although 65.4% of respondents were aware of the existence of mental health services, one-third still lacked understanding of how to access them. Suggested interventions from the congregation include routine educational programs in the church, the provision of free consultations, the establishment of support groups, the cultivation of a listening culture, and structured spiritual accompaniment. The study reveals a gap between awareness and action, influenced by religious stigma and limited information. It recommends integrating mental health literacy into pastoral ministry, establishing a pastoral referral system, and fostering collaboration between the church and professional practitioners. The church is positioned as an agent of social transformation capable of providing a safe space for holistic healing—physical, psychological, and spiritual—within the framework of a theology of shalom. This research offers practical contributions to the development of contextual pastoral care and enriches academic discourse on the intersection of religion, culture, and mental health in Indonesia.

BACKGROUND

Mental health has become an increasingly urgent global concern, particularly amid rapid social, economic, and technological transformations. In Indonesia, although public awareness of the importance of mental health continues to rise, social stigma and limited access to mental health services remain significant obstacles to comprehensive care (Sumolang & Zamli, 2025). The religious context, particularly within Christian communities, offers potential space for holistic interventions that

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integrate spiritual dimensions with psychosocial approaches. The Christian Evangelical Church in Minahasa (GMIM), as one of the largest Protestant denominations in North Sulawesi, has a strong communal network that significantly influences social norms and responses to various issues, including mental health.

In the local context, the congregation of GMIM Golgota Bukit Ranomuut Permai represents an urban community facing the complexities of modern life—ranging from economic pressures and changing family structures to generational identity challenges. The church's response to mental health issues reflects not only theological understanding but is also shaped by distinctive Minahasan cultural values. Therefore, understanding how this congregation perceives, responds to, and integrates mental health issues into congregational life is essential for developing relevant and evidence-based pastoral care strategies.

Mental health has increasingly become a widely discussed issue in recent years. One of the major areas of concern is the rise in suicide cases among adolescents, which serves as a critical indicator of mental health disorders (Wulandari & Elviany, 2024; Karisma et al., 2024; Fatha et al., 2025). Problems arising from mental health disorders include impaired communication between individuals. A proposed solution to reduce bias or miscommunication in interactions between mental-health survivors and those who are mentally healthy is to foster mutual understanding and empathy (Rita Nurwulan Sari, 2023; Mikraj, 2025). Contemporary research further demonstrates that adolescent mental health is increasingly threatened by digital social dynamics, particularly through the phenomenon of cyberbullying (Arifin, 2025; A. Puteri et al., 2025). Findings from Ni'mah (2023) show that technology-based aggressive behavior—such as defamation, dissemination of humiliating content, or online exclusion—has significant psychological impacts on adolescents, including depression, anxiety, sleep disturbances, and suicidal ideation. These effects are exacerbated by the anonymity and virality of digital media, which expands the reach and intensity of attacks, leaving victims feeling isolated even within private spaces. Studies by Yulianti et al. (2024), Kasingku (2024), and Dewa Ayu Eka Purba Dharma Tari & Putu Karpika (2024) reinforce these findings by showing that victims of bullying—whether direct or online—experience reduced self-esteem, fear of the school environment, and disruptions in social and academic functioning, cumulatively undermining long-term mental well-being.

On the other hand, social media not only plays a role as a potential medium for cyberbullying but also serves as a platform for education and advocacy in raising mental health awareness (Rakhman et al., 2024). Tulandi (2021) highlights how Instagram accounts such as *Ubah Stigma* employ educational and informative communication strategies to deconstruct social stigma surrounding mental disorders in Indonesia. Through easily digestible visual content, two-way interaction, and collaboration with psychologists and influencers, digital platforms can function as inclusive and participatory tools for mental health literacy (Poerwanti et al., 2025; Indrasari, 2024). This approach demonstrates the potential transformation of social media from a threat into a solution, provided it is curated with caution, scientific accuracy, and cultural sensitivity.

Nevertheless, the effectiveness of mental health literacy—whether through digital media or interpersonal approaches—is still constrained by structural and cultural factors. Rudianto (2022) found that although Generation Z generally understands the importance of mental health, this awareness does not always translate into preventive actions or the pursuit of professional help, due to persistent stigma, limited access to services, and the misconception that mental disorders reflect moral weakness or insufficient faith. Similar findings are reported by Fitriah et al. (2023) and Octaviana & Safitri (2025), who highlight the paradox of social media use: while it provides a space for expression and social support, it also triggers social comparison, performance anxiety, and addiction that worsen mental health. Thus, responses to mental health issues require a multi sectoral approach that integrates digital literacy, pastoral accompaniment, public policy, and social norm transformation.

Although international literature has extensively examined the role of religion in mental health, and several local studies address stigma and community perceptions, significant gaps remain

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in understanding micro-level dynamics within local congregations particularly within the GMIM context, which possesses distinct theological, social, and cultural characteristics. No existing research has thoroughly explored the narratives, attitudes, and concrete practices of the GMIM Golgota Bukit Ranomuut Permai congregation regarding mental health, thereby limiting the development of contextual and evidence-based pastoral approaches.

This study aims to analyze the perceptions, attitudes, and responses of the GMIM Golgota Bukit Ranomuut Permai congregation toward mental health issues and to identify the theological, social, and cultural factors shaping those responses. Through an in-depth qualitative approach, this research seeks to reconstruct local understandings of mental health and propose an integrative framework between pastoral ministry and community based mental health approaches.

The findings of this study are expected to provide practical contributions for churches in designing pastoral care programs responsive to congregational mental health needs. At the policy level, the research may serve as a foundation for collaboration between religious institutions and the health sector to expand community-based mental health service coverage. Academically, this study enriches the literature on the intersection of religion, culture, and mental health in Indonesia, particularly within the Minahasan Protestant context.

The novelty of this study lies in its specific focus on a GMIM congregation a denomination relatively unexplored in mental health research and its integration of theological, anthropological, and psychosocial perspectives. By employing participatory ethnographic methods and in depth interviews, this study not only documents congregational perceptions but also uncovers the local mechanisms through which meanings of health and mental suffering are constructed, thereby offering an authentic and contextually rooted intervention model.

METHOD

This study employed a descriptive qualitative approach to understand the perceptions, attitudes, and responses of the congregation of GMIM Golgota Bukit Ranomuut Permai toward mental health issues. A qualitative approach was chosen because it enables the researcher to explore the meanings, experiences, and socio-cultural contexts that shape how congregants understand and respond to mental health. The research was conducted at GMIM Golgota Bukit Ranomuut Permai, located in Malendeng Village, Perkamil District, Manado City, North Sulawesi—an urban community facing various pressures of modern life that may potentially affect the mental well-being of its members.

The population of this study consists of all members of GMIM Golgota Bukit Ranomuut Permai. Given the limitations of time and resources, the study utilized purposive sampling to select informants considered representative and who have direct experience or involvement with mental health issues, either as individuals who have experienced them, as church ministers (Pelsus), or as youths actively engaged in congregational activities. A total of 26 respondents participated through an online questionnaire distributed via Google Forms. The majority of respondents came from the special ministers (Pelsus) and youth groups, with a gender composition of 9 males and 17 females, and a predominant age range between 30–35 years.

The primary instrument for data collection was an open-ended questionnaire designed to explore respondents' initial understanding of mental health, personal or social experiences related to mental disorders, coping strategies employed, and perceptions of available mental health services. The questionnaire included open-ended questions that allowed respondents to express their views freely and comprehensively, enabling the collection of both quantitative data (such as response frequencies) and qualitative data in the form of narratives and personal reflections.

Data analysis was conducted using thematic analysis. First, all responses were compiled and categorized into major themes such as: (1) level of awareness of mental health issues, (2) personal or social experiences with mental disorders, (3) coping strategies used, (4) barriers to accessing mental health services, and (5) congregational recommendations for church-based interventions. The data were then reduced, coded, and interpreted to draw conclusions relevant to

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the aims of the study. Data validity was strengthened through source triangulation by comparing responses from different respondent backgrounds (youth, church ministers, general congregants) to ensure consistency and depth of findings.

Through this method, the study seeks not only to document the local reality but also to provide an empirical foundation for the development of pastoral programs that are sensitive to the mental health needs of the congregation within the theological and cultural context of Minahasa.

HASIL DAN PEMBAHASAN

Hasil

This section presents the descriptive analysis of 26 questionnaire responses from the congregation of GMIM Golgota Bukit Ranomuut Permai regarding mental health issues. The results are displayed in tables and diagrams to clearly illustrate data patterns related to respondents' profiles, levels of exposure to mental health information, experiences of stress, knowledge of available services, as well as barriers and proposed interventions. The following description is purely a presentation of findings and does not yet involve interpretation or discussion.

Table 1. Distribution of respondents by gender

Gender	Frequency	Percentage (%)
Male	9	34,6
Female	17	65,4

The data in **Table 1** indicate that the respondents are predominantly female (65.4%), while males constitute 34.6%. This suggests that female congregation members were more actively involved in completing the questionnaire compared to male respondents.

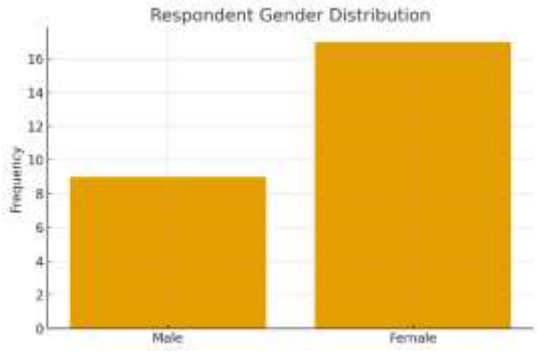

Figure 1. Bar chart of respondents based on gender

As shown in **Table 2,** most respondents belong to the age group above 35 years (61.5%), followed by those aged 26–35 years (26.9%). Respondents from the adolescent and young adult groups are relatively few, which means that the findings predominantly reflect the perspectives of adult members of the congregation.

Table 2. Distribution of respondents by age group

Age Range	Frequency	Percentage (%)
<18 years	1	3,8
18–25 years	2	7,7
26–35 years	7	26,9
>35 years	16	61,5

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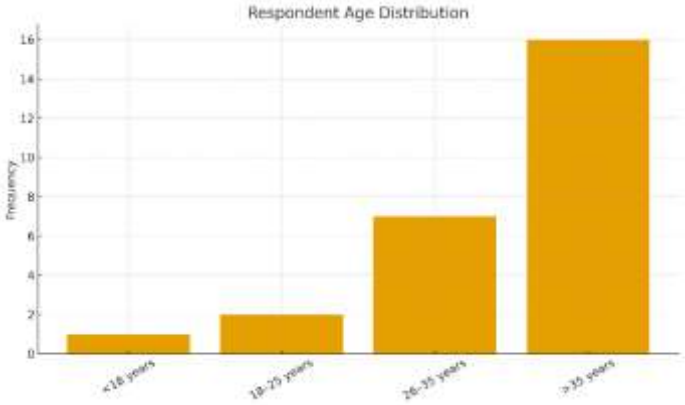

Figure 2. Bar chart of respondents by age range

Table 3. Respondents' exposure to mental health issues

Category	Frequency	Percentage (%)
Have heard about mental health issues	25	96.2
Have never heard	1	3.8

Table 3 shows that nearly all respondents (96,2%) have heard about mental health issues, with only one respondent reporting no prior exposure. This indicates a relatively high baseline level of awareness among the congregation.

Table 4. Respondents' experiences with stress, anxiety, or depression

Category	Frequency	Percentage (%)
Have experienced in recent months	17	65,4
Never / not reported	9	34,6

In **Table 4**, 65,4% of respondents report having experienced stress, anxiety, or depression in the past several months. This indicates that psychological pressure is a real and common experience among the congregation.

Table 5. Respondents' knowledge of mental health services

Category	Frequency	Percentage (%)
Know available services	17	65,4
Do not know	9	34,6

A total of 65,4% of respondents report knowing about available mental health services or where to seek help, whereas 34,6% do not. The presence of one third of respondents who lack such knowledge highlights the need for more targeted information dissemination at the congregational level.

Table 6. Barriers faced by respondents regarding access to mental health care

Barrier	Frequency
Lack of knowledge	12
Fear of stigma or judgment	8
Cost	3
Not knowing where to go	2
Discomfort in sharing problems	1

Table 6 shows that the most frequently mentioned barriers are lack of knowledge (12 mentions) and fear of stigma or social judgment (8 mentions). Structural barriers such as cost and lack of information about service locations appear but with lower frequency.

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Table 7. Respondents' suggestions for congregational interventions

Suggestions / Solutions	Frequency (Qualitative)
Regular education/awareness programs in church	most frequent
Free or affordable consultation/checkups	frequent
Formation of mental-health–supportive communities	frequent
Mutual support and learning to listen	fairly frequent
Structured spiritual accompaniment	mentioned by some respondents

The proposals center around four themes: (1) regular mental health education, (2) providing free or affordable consultations, (3) forming support groups or caring communities, and (4) strengthening spirituality while still opening space for professional assistance.

Discussion

1. General Profile of Respondents

The findings from the 26 respondents of GMIM Golgota Bukit Ranomuut Permai provide an initial overview of the socio-demographic characteristics that frame their awareness and experiences related to mental health issues. The majority of respondents are female (65.4%) and aged above 35 years (61.5%). This composition suggests that adult female congregants tend to be more actively involved in participating in such surveys, which aligns with common patterns of engagement in church-based social and organizational activities.

The predominance of female respondents may reflect broader trends in which women are generally more active in religious communities. Prior research suggests that women tend to participate more frequently in church activities, particularly in social ministries and congregational development (Mundo et al., 2023; Runkat, 2022). This may also relate to cultural gender norms within local contexts in which women are more inclined toward relational and communicative activities. Additionally, literature indicates that women are often more open in expressing emotional experiences, including stress and anxiety (Kuraesin, Febri, & Rifa, 2025). Therefore, their dominance in this study may shape the findings with a more emotionally expressive perspective.

Meanwhile, the majority representation of adults over 35 years suggests that the findings predominantly reflect the experiences of mature and middle-aged individuals. This age group typically encounters various life pressures—such as employment, marriage, family responsibilities, and church ministry duties—that may contribute to psychological stress. They also tend to have higher exposure to social and health information, including through church meetings or ministry groups. Consequently, while the findings reflect a well-informed and experienced demographic, they may not fully capture the perspectives of younger congregants who face different psychological challenges, such as academic pressure or digital dependency.

2. Exposure to Mental Health Issues

The congregation demonstrates a remarkably high level of exposure (96.2%) to mental health issues, indicating that awareness is already well established. In the Indonesian context, this represents a positive development, considering that in previous years mental health discussions were often considered taboo or irrelevant to religious life (Puteri & Rahimah, 2024; Rahmah et al., 2024; Maharani & Yazid, 2024).

This high exposure may be attributed to increased attention from media, government, and religious institutions regarding mental health. Churches in Indonesia, including GMIM, have recently begun opening spaces for discussions and pastoral support concerning emotional well-being. According to mental health literacy theory, exposure is a foundational step toward developing broader literacy involving recognition of disorders, understanding pathways to help, and fostering positive attitudes toward seeking assistance (Syafitri et al., 2024). Thus, this finding indicates that the congregation has a basic level of mental health literacy, though it does not necessarily guarantee deep understanding or readiness to seek professional help.

Nevertheless, high exposure does not always correspond to accurate understanding. Several studies show that despite frequent encounters with the term "mental health," perceptions

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may still be shaped by stigma or misconceptions—for example, viewing mental disorders as a sign of weak faith or inadequate prayer (Prabeus et al., 2015). Therefore, the next critical step is ensuring that this awareness is grounded in accurate and theologically sound understandings.

3. Experiences of Stress, Anxiety, and Depression

A significant proportion 65,4% reported experiencing stress, anxiety, or depression in recent months. This suggests that psychological distress is a real and widespread phenomenon among the congregation. This is consistent with national surveys indicating heightened stress and anxiety levels in the post–COVID-19 period (Hasnasya, 2025; Handayani et al., 2020).

From the perspective of pastoral psychology, stress among congregants may stem from economic pressure, family responsibilities, church ministry dynamics, or interpersonal conflicts. Stress occurs when individuals perceive demands as exceeding their available resources (Wiharjanto et al., 2024). Within the church context, this may involve spiritual expectations, multiple role responsibilities, or feelings of inadequacy in fulfilling religious obligations.

Interestingly, the proportion of respondents experiencing psychological distress mirrors the proportion who are aware of mental health services (65,4%). However, this does not imply that those experiencing distress necessarily seek help. Numerous studies in Indonesia indicate that the main barrier is not the absence of problems, but rather the reluctance to seek help due to stigma and misunderstanding (Rasyida et al., 2019). This underscores the need for the church to serve as a safe and non judgmental space for congregants to express and discuss their struggles.

4. Knowledge of Mental Health Services

The data show that 65.4% of respondents are aware of mental health services, while 34.6% lack such knowledge. This highlights a gap in the congregation's help-seeking literacy—specifically, knowledge about where and how to access professional care.

In religious communities, help-seeking behavior is influenced by two important dimensions: (1) spiritual belief that God is the primary source of healing, and (2) perceptions of professional mental health services. While faith can strengthen psychological resilience (Palinggi et al., 2025), it may also limit help-seeking if interpreted exclusively (e.g., "prayer alone is enough"). Therefore, mental health education in churches must align with Christian faith by emphasizing that God can also work through mental health professionals.

The information gap among one-third of respondents suggests the need for church-based educational interventions, such as thematic sermons, seminars, or training for lay leaders on early detection of psychological distress. This positions the church as an initial point of reference and information-sharing hub.

5. Barriers to Accessing Mental Health Care

The main barriers identified include lack of knowledge (12 mentions) and fear of stigma (8 mentions). Structural barriers such as cost and lack of information about service locations are less common.

Studies (Arina et al., 2021) reinforce the idea that stigma is a major deterrent to help-seeking. Within church contexts, stigma may manifest in beliefs such as "believers should not feel depressed" or "anxiety is a sign of weak faith." Such views may lead individuals to conceal their struggles. Hence, pastoral interventions must work to dismantle these narratives, emphasizing that psychological challenges are not incompatible with faith and that seeking help is a responsible act of stewardship over one's God-given life.

The prevalence of knowledge-related barriers also highlights the need for mental health literacy programs within the church. This includes educating congregants about the symptoms of psychological distress, appropriate supportive responses, and referral pathways. Churches can collaborate with healthcare centers or Christian counseling services for this purpose.

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6. Congregational Proposals for Mental Health Interventions

The qualitative data indicate five primary suggestions:

1. Regular education or awareness programs,
2. Free or affordable consultation services,
3. Formation of mental health support communities,
4. Cultivating a culture of mutual listening and encouragement, and
5. Structured spiritual accompaniment.

These proposals reveal that the congregation recognizes the importance of mental health and envisions concrete roles for the church. Educational programs can include sermons, seminars, or catechetical classes discussing mental health from both theological and psychological perspectives. Spirituality can serve as a healing resource when integrated appropriately (Muthmainnah, 2025).

Affordable consultations may involve partnerships with Christian mental health professionals. Support groups can provide safe spaces for sharing and encourage peer-based emotional support (Prakosa et al., 2025). The emphasis on mutual listening aligns with pastoral care practices centered on empathy and presence. Structured spiritual accompaniment ensures that faith remains integral to healing without minimizing the importance of professional care.

7. Implications for Church and Pastoral Ministry

Several key implications emerge:

1. Expansion of Mental Health Literacy
   Churches must strengthen mental health education through training and awareness programs.
2. Integration of Faith and Psychology
   Both domains complement each other and should be harmonized in pastoral teaching and practice.
3. Development of Pastoral Referral Systems
   This ensures responsible and ethical pathways from pastoral support to professional care.
4. Empowerment of Congregational Support Networks
   As a community of faith, the church can be a powerful source of emotional and social support.
5. Church-Based Anti-Stigma Advocacy
   The church can model compassionate and accepting attitudes toward mental health struggles.

8. Synthesis and Reflection

Overall, the findings reveal that the congregation possesses high awareness of mental health issues but still faces barriers related to knowledge and stigma. This reflects a transitional stage toward becoming a more open and supportive community.

Theologically, mental health can be understood as part of God's shalom—a holistic state of well-being encompassing spiritual, emotional, social, and physical dimensions. Sociologically, religious communities possess significant potential as psychosocial support systems due to their relational structures and moral authority.

This study affirms the need for collaboration between faith and professional disciplines and underscores the role of the church as not only a place of worship but also a space of healing. Here, every individual can experience love, acceptance, and hope for mental well-being.

CONCLUSION

This study successfully reveals a comprehensive overview of the perceptions, experiences, and responses of the GMIM Golgota Bukit Ranomuut Permai congregation regarding mental health issues within the theological, social, and cultural context of Minahasa. Although the research involved a limited number of respondents (26 individuals), the findings indicate that the congregation's basic awareness of mental health is relatively high, with 96.2% stating that they have previously heard about the issue. However, this high level of exposure does not always correspond to a deep

understanding or the willingness to seek professional help, which remains hindered by limited knowledge and fear of social stigma.

A total of 65.4% of respondents reported experiencing stress, anxiety, or depression in recent months, indicating that psychological disturbances are a real and pressing concern that requires serious attention from the church. Given the predominance of adult and female respondents—who tend to be more emotionally expressive—the study also underscores the need for inclusive approaches targeting younger age groups and men, who may be more reluctant to discuss their mental health challenges.

The primary obstacles identified include limited knowledge of available mental health services and fear of negative judgment from the community, reflecting the presence of implicit stigma within religious settings, such as the belief that mental health struggles are associated with weak faith. Consequently, the church holds a central role in deconstructing such stigma through pastoral education that integrates Christian faith with contemporary psychological principles.

The congregation themselves offered constructive suggestions, including the need for regular educational programs, the formation of support groups, the provision of free consultations, and structured spiritual guidance. These recommendations reflect the community's readiness to transform into a space for holistic healing. As a faith community, the church is called not only to nurture spiritual well-being but also to safeguard the mental health of its members as part of God's shalom. By developing pastoral referral systems, enhancing mental health literacy, and strengthening social support, GMIM can serve as a model for holistic ministry that is relevant, contextual, and grounded in love.

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