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An exploratory survey of some Christian leaders' views re: causes and treatment of mental health and substance abuse problems : "Let go and let God?" or more?

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ABSTRACT

This exploratory study was undertaken to determine the attitudes of leaders in Christian churches toward problems with mental health or substance abuse issues. As beliefs about causation of these problems may directly impact types of help offered to those suffering, leaders were also asked to identify particular types of treatment they recommended.

This study was conducted in two parts. The first part involved a snowball sampling of known associates of the researcher who were asked for their help to enroll volunteers for an online survey. The survey asked about: how many and for what purpose the leaders met with congregants; the interventions they often recommend for those seeking help with emotional issues or problems with addictions or addictive type tendencies; and what, if any, trainings they had participated in regarding church leadership or mental health treatment. A total of 43 individuals completed the survey. The second part of the study involved phone or in person interviews with four individuals who had completed the survey and agreed to answer follow up questions. Most questions in the interview focused on leaders' understandings of the causes of mental health and addiction issues.

The findings showed that, of the leaders surveyed, most would encourage congregants to seek help in addition to that of their spiritual leaders' counsel and prayer if suffering from mental health problems or addictions. Leaders also showed empathy for those suffering from these problems, as well as humility about their own abilities to deal with such complex issues on their own.

AN EXPLORATORY SURVEY OF SOME CHRISTIAN LEADERS' VIEWS RE:

CAUSES AND TREATMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE

PROBLEMS – "LET GO AND LET GOD?" OR MORE?

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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I thank my God every time I remember you…Phillipians 1:3

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Figures

CHAPTER I

Introduction

Crystal[1] was 17 years old when she was admitted to residential treatment for her drug and alcohol use. As she got clean and sober and began to explore the underlying reasons for the addiction, she acknowledged to herself and others that she had been abused, physically and sexually, by her biological father from the age of two until eight. She was also diagnosed with major depression and borderline personality traits. One day, while checking her back in to the facility after a weekend at home, Crystal began crying. When I asked her what was wrong, she told me that her mother and step-father had taken her to church that morning so she could "be healed." I asked her what she meant. She stated that her parents didn't believe that there was something wrong with her brain. They thought that she was a "bad" girl, and that she had problems because she wasn't praying enough. They took her to the pastor of their church, who told her that until she could be truly sorry for all of the things that she had done, she would continue to be possessed by a "demon" and not ever fully heal. He suggested that she quit taking her anti-psychotic medication and start to read her Bible more.

Crystal was devastated. She needed her family's support during her mission to get clean and stay sober. Not only did she feel like they couldn't help her, she felt like they didn't understand her problem. She explained that she always tried to make the best decision possible, but she sometimes messed up. As she talked about her interaction with the pastor at the church,

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[1] Identifying information has been changed.

she became visibly angry and stated that she was never going back, and would no longer talk to her parents if they chose to continue to attend. Crystal's faith was one of the things in her life that she was able to cling to when things were hard, and the frustration and pain that she was dealing with because of the beliefs of the leaders of her church was almost unbearable for her.

As social workers address the needs of the people served, one of the key elements is the spiritual nature of the person. It is essential that we work to understand the values and beliefs that our clients present with in order to help with healing the whole person. An important step in this process for many people may be talking with the leader within their spiritual community. If the leader is not in agreement with therapy, medication, or other aspects of treatment, the person may become conflicted about how to deal with this ambiguity and not know how to proceed. Also, it is likely that those who are already in a Christian community would go first to a spiritual leader to ask for help if something were not right in their lives. It is important for social workers to understand the responses that those leaders may have in order to facilitate conversations about causes and treatment for the client.

This project is designed to answer the question "How do those in designated leadership in Christian churches understand the causes of mental health and substance abuse problems, and what type of help do they recommend?" The information collected in this study can be used by social workers and leaders in Christian churches alike in order to help bridge the gap in working to treat the whole person in conjunction with his or her spiritual beliefs.

CHAPTER II

Literature Review

This section will address ideas found in relevant literature regarding some of the theories about causes of mental illness and addiction. It will also include research that has been done about the importance of religion and spirituality in the lives of those with mental illness or addiction, and the impact of the values and beliefs of church leaders on the attitudes and actions of those within their churches.

Definitions

For the purposes of this research, Christians are defined as those who believe that "Jesus Christ is the Messiah, sent by God. They believe that Jesus, by dying and rising from the dead, made up for the sin of Adam and thus redeemed the world, allowing all who believe in him to enter heaven. Christians rely on the Bible as the inspired word of God" (Dictionary of Cultural Literacy, 2005 reference: Christian).

Substance Use/Addiction

For many people, the idea of drug addiction is a scary one. We tend to think that addiction means that addicted persons are making the wrong choices, and that they have total control over what they are doing. The word "addict" often conjures up pictures of people who are homeless, haven't shaved or showered in weeks or maybe months, and will go to any lengths, including stealing from loved ones, in order to obtain the high they are looking for. For those without an addiction, it can be easy to think that recovering from addiction is about trying hard

enough, and that if someone's will is strong enough, the drugs won't have control anymore. In the Christian church, especially those that are more fundamentalist, addiction can be seen as a manifestation of sin, and an unwillingness to repent and turn to God for healing and restoration (Mate, 2008).

There are a number of theories about the root causes of addiction. As the amount of research increases, we learn more about the ways that the brain is impacted by the use of substances and other mood altering activities, such as eating, sex, and gambling. Certainly, there is the idea that someone is predisposed to addictive behaviors because of genetic loading. Other researchers suggest that addiction is purely a matter of behavior and environment, and has no basis in biology or genetics. Still others state that all of these things are important. Gabor Mate, in his book *In the Realm of Hungry Ghosts* says "Brain development in the uterus and during childhood is the single most important biological factor in determining whether or not a person will be predisposed to substance dependence and to addictive behaviors of any sort, whether drug related or not." (2008, p.188.)

If we work with the idea that addiction affects the whole person (Mate, 2008), then certainly addiction and spirituality would have an impact on each other. The question to ask then becomes whether the addiction caused the spiritual issues or the other way around. An addiction can be an attempt to find something to fill a void in one's life and struggling with finding spiritual direction, or questioning one's values and beliefs, could be enough for someone to look to drugs or another substance to answer those questions (Mate, 2008).

Once we understand the cause of addiction, it will be easier to provide help for those struggling with restoring their lives. Ultimately, those who are suffering deserve help and support as "…they are unable to develop compassion toward themselves and their bodies while

4

they are regarded as outcasts, hunted as enemies, and treated like human refuse." (Mate, 2008, p.318) This type of healing cannot happen in a vacuum. There must be a supportive community for those who cannot make a choice to get better. (Mate, 2008)

Mental Illness

In John 9, the Bible tells us that one of Jesus' disciples came to him with a man who had been born blind. His question was "Who sinned, this man or his parents, that he was born blind?" (John 9:2, Today's New International Version) Jesus' answer was that neither had caused the problem. He healed the man, who then went on to tell everyone around him what happened. In another story, we hear of a man who was acting erratically. He was viewed by those around him as strange. Jesus stands in front of him, and casts out a "legion of demons." There are no reports that anyone asks this time who it was that sinned. The demons were the cause of the problem, which was solved when they were sent out of the man.

It is important to note that we live in a society that, in general, is more comfortable with the idea of terminal illness or physical impairment than the idea of mental illness (Martinez, Piff, Mendoza-Denton & Hinshaw, 2011). People with mental illness are often portrayed in the media as dangerous, violent, and suicidal. Occasionally, films such as *A Beautiful Mind*, or *The Soloist* will choose to show some with mental illness in a more positive light with skills and abilities that make them more socially appealing -- however, not before emphasizing the negative ways that those individuals are different from those around them.

There is no single cause for all mental health problems. As with addiction, the number of theories about the reasons for these issues is endless. In discussing the phenomena of "hearing voices," a study done in 2004 lists more than ten potential causes, including fatigue, brain damage, or spiritual communication. (Ritscher, Lucksted, Otilingam & Grajales, 2004) Taking

into consideration the countless number of issues listed as Axis I diagnoses in the most recent DSM IV TR, and there could be an infinite number of combinations of causes for any persons perceived mental health issues.

Free Will vs. Determinism in Mental Health and Addiction

One of the important issues to take into consideration in the understanding of mental illness and addiction is the idea of free will and determinism. For centuries, leaders in every sect and denomination of Christianity have debated how much control God has in one's life (Seligman, 2007). To review this in detail would take hundreds of pages and is better discussed elsewhere. In theology, this argument typically centers on whether God chooses those whom He redeems or whether individuals make a decision to follow God, with limited or no prompting on His part (Seligman, 2007).

As this issue is translated into the understanding of the nature of mental health and addiction issues, it would certainly have an impact on the suggested treatment. If humans are acting entirely on their own, without any influence or control by God or other outside forces, then it is the decisions we make that result in depression, anxiety, or addiction. Generally, an extreme view of free will would most likely endorse the viewpoint that those who have mental health issues or addictions are suffering because of their own sin, which could potentially cause the person struggling to feel additional shame and guilt regarding the problem with little or no hope for change (Sims, 2007).

Those who believe in determinism would most likely promote the idea that someone who is struggling with mental illness or addiction is dealing with an issue that is out of the control of the individual. There is no choice but to act destructively and lose control of emotions (Krober

2007). If there is no responsibility for actions or decisions, there is little or no motivation to change behaviors or decisions (Sims, 2007). As the old adage goes: "the devil made me do it."

However, if we approach this issue with moderation, and take into consideration information from both sides, we end up with pictures of people who are ultimately making decisions based on the ways they interpret and understand situations (Vohls & Baumeister, 2009). The person struggling with depression may be suffering because she not only has a number of close family members who deal with depression, but also because she has a number of environmental stressors that she can't control. The recovering alcoholic may relapse after a devastating life event, not because he's weak, but because he needs a coping skill that is familiar to him and his brain chemistry has already been altered to make him less able to quit after one drink than someone who has never struggled with addiction. A more balanced viewpoint supports the idea that although people make decisions based on their lifestyle and education, there is some level of the way that we function that is decided for us (Vohls & Baumeister, 2009). If these two things are truly interacting to make us who we are, then it becomes easier to allow others a bit of grace and patience when they are struggling. We can accept people for who they are, while at the same time encouraging them to be better (Sims, 2007).

Spirituality in Mental Health and Addiction Treatment

As people who are struggling with mental health and addiction issues are seeking help, it is important to understand whom they are approaching, and what their expectations are of the process. In a study done in 2009, Brian Post and Nathaniel Wade identified that when individuals are seeking help from an identified mental health professional, such as a therapist, most are open to talking about religious or spiritual issues but may have no preference about the identified religion of their provider as long as that person is willing to work within the religious

values of the client. The role of the provider should be clearly defined within this relationship, however, as it may not be ethical for the therapist to perform a religious ritual in this setting (Milstein, Manierre & Yali, 2010).

Religion and spirituality can be comforting when someone is struggling, and many people look to their traditions and beliefs to assist them in times of trouble (Webb, Stetz & Hedden, 2008; Milstein, Manierre & Yali, 2010). Religious values and beliefs impact the way that people see their own issues as well as how they interact with those around them (Wesselmann & Graziano, 2010).   Religious leaders can also be a primary means of support for those who are being impacted by a mental health or addiction issue (Hartog, & Gow 2005; Payne, 2009).

The impact of one's religious beliefs on the management of mental health or addiction issues can be positive or negative. Overall, a strong religious affiliation is correlated with a positive outcome (Milstein, Manierre, & Yali 2010; Blazer, 2009); however, the role of other factors must be taken into consideration as well. If someone views God as more forgiving and understanding, the likelihood of struggling with depression or anxiety has been showed to be lower, whereas someone who sees God as judgmental and punishing is more likely to report depression-like symptoms. (Koenig, Pargament & Nielson, 1998).

It is also important to note, however, that at times a strong "religious involvement not only hinders mental health, it becomes intricately entangled with neurotic and psychotic symptoms" (Blazer, 2009, p.281).   More recent studies have begun to ask questions about the connection between an unusually strong religious focus and mental health issues. For some, religion may be exacerbating the mental health issues due to the pressure and expectations

created in strong religious communities, and for others, the strong religious commitment may be a symptom of the mental health issue (Leavey, 2010; Sims, 2007).

Treating Mental Health and Addiction from within the Church

The Christian church is separated into a number of different denominations. It would be impossible to discuss in this brief literature review the differences between each denomination and the reasons for the different beliefs. In acknowledging that there are these differences, however, one can begin to understand that each denomination, and probably each individual congregation within each denomination, would have a different understanding of the relationship between spiritual experience and mental health or addiction.

The importance of the views of the leaders in the Christian church cannot be undervalued. Most churches take the process of choosing leaders for their congregations very seriously. These chosen men and women are often viewed as authorities on the faith and religious matters, and the way they understand issues, such as mental illness and addiction, often lays the foundation for the values and beliefs of those they lead (Mathews, 2008; Trice & Bjorck, 2006; Payne, 2009). People will often go first to their church leaders for help in dealing with crisis and will rely on those leaders for answers about the best way to solve the problem. (Milstein, Manierre & Yali, 2010). It is essential that church leaders have as much information as possible al about the problems they are trying to help solve (Leavey, 2010).

Most Christian Churches look to the Holy Bible as the foundation for the way they interpret different issues within the world. There are many different ways to interpret scripture, and those differences are what often cause the denominational divisions in Christianity. Interpretations of the Bible and its meanings can range from literal to figurative, and can be varying on any issue. In general, research shows that those with more conservative theologies

tend to associate mental health issues with spiritual causes, whereas more liberal viewpoints are likely to separate the two (Hartog & Gow, 2005; Payne, 2009).

One way to understand how those in leadership view mental health and addiction issues is to look to the literature endorsed by the Christian Church for congregants to read about faith and life. Often called self-help books, a recent study done by Marcia Webb, Kathy Stetz and Kristin Hedden found that the authors of these books often recommended that those struggling with depression "…take actions such as assuming responsibility for their sins, praying, focusing their minds on God, and practicing religious rituals" (2008, p.706). While a large portion of the books reviewed suggested that increased faith in the ability of God to heal the affliction, only 2% of the authors suggested that God would use mental health professionals such as counselors to help with the problems (2008).

As the views of a specific religious community are often shaped by the leadership, it is also important to understand the impact of community on someone managing difficult life circumstances. The way a group of people views a problem will have an impact on the resources an individual has to deal with that problem. If a church congregation has a negative opinion of someone suffering with mental health or addiction, he or she will be less likely to have the social support needed to solve the problem, which can lead to someone not acknowledging that there is a need for help, not seeking appropriate treatment, or early termination of treatment (Martinez, Piff, Mendoza-Denton, & Hinshaw, 2011; Wesselmann & Graziano, 2010).

Summary

After reviewing available literature, it becomes clear that for mental health professionals to support those within Christian churches who may be struggling with mental health or addiction problems, leaders of those churches should be surveyed to find out what they

understand and recommend when faced with these issues. "Minimal discussion exists in the literature, however, about how clergy's views shape their decisions about mental health referral and intervention" (Payne, 2009, p. 356). The role of church leadership cannot be minimized when understanding an individual's view about his or her struggle. A relationship between clergy and mental health professionals could be beneficial for those assisting people in need, but would be especially helpful for those dealing with these major issues (Milstein, Manierre &Yali, 2010).

CHAPTER III

Methodology

This project was designed to answer the question "How do those in designated leadership in Christian churches understand the causes of mental health and substance abuse problems, and what type of help do they recommend to church members seeking their guidance?"

Research Design

The research method for this project was a mixed-method one. It was a combined quantitative and qualitative empirical study of spiritual leaders' treatment recommendations to the members of their ministries. This method was chosen to allow for collecting a larger set of quantitative data regarding what, if any, treatment was recommended based on the spiritual leader's understanding of the basis for the problem. Qualitatively, it allowed for follow up questions addressed to a smaller group who would volunteer to be interviewed in greater depth regarding the bases for these participants' beliefs about the causality of mental health and substance abuse problems, whether it was based in formal mental health education, Biblically based, denomination taught, or a combination of these.

In working to gather quantitative data, some of the questions asked were:

*How often are you approached by a congregant to meet individually regarding a problem in his/her life?

*What percentage of the individual meetings that you have involve talking about emotional states? (For example, sadness, anger, joy fear, etc.)

* What percentage of the individual meetings that you have involve discussion about substance use or other addiction (internet, gambling, pornography, etc.)?

*How likely are you to recommend each of the following interventions to one of your congregants? Group meetings (AA, NA, etc.); Ongoing individual meetings with you; Prayer; Referral to Mental Health Professional (social worker, therapist, etc.); Referral to psychiatrist; Scripture readings; Other (please explain).

For the full text of this survey, please refer to Appendix C.

Once the quantitative data were collected and aggregated, and conclusions were drawn about the number of times leaders are approached to help with mental health and substance abuse issues and the common and unusual themes occurring in their responses.

The qualitative data collected from the smaller number of interviewees included more information about how leaders understand the origins and causes of mental health and substance abuse problems. Some of the questions asked were:

*Tell me about your beliefs about some of the causes of depression and other mental health problems in your congregants.

*What are your thoughts about the theory that some mental health problems may be a result of chemical deficiencies in the brain?

*Tell me about your beliefs about substance abuse and addiction to things like gambling, internet or pornography. How are these problems generated? How can your congregants manage such issues?

*If your congregants were to ask you for scripture(s) to read about either mental health/emotional problems or addiction issues, to which would you refer them?

Informed consent for the Qualitative Survey can be found in Appendix D.

The qualitative responses allow for increased understanding regarding the beliefs that leaders have about the causes of mental health issues. This information was more easily

captured in an interview as opposed to an online survey due to the ability of the researcher to ask clarifying questions and for respondents to elaborate their responses more fully.

Information found in this study will be useful for social workers who work in conjunction with Christian faith communities to understand the views of the leadership in helping their congregants. With this information, social workers will be able to offer psychoeducation that may influence leaders' practices and provide services that are more in line with the goals and beliefs of the individual church or denomination as well as to meet the needs of their congregants.

Sample

The sample population for this study included those who are in identified leadership positions within Christian Churches. Participants were contacted through a snowball sampling of known associates of the researcher. Those associates were asked to forward the survey information to those they knew who were designated church leaders, or who might know someone designated as a leader.

Participants in this study are adult English speaking leaders in Christian Churches. They were asked to identify the denomination of Christian Church they were serving in at the time of the survey. If they did not identify as leaders within the Christian Church, they were excluded from the study. The desired sample size for the quantitative study was approximately 50 people. The desired sample size for the qualitative in-depth interviews was between four and six people.

Due to the wide geographic area of the associates, it was expected that participants in the survey would be from all parts of the United States, and that there might have been international participants as well. Participants were emailed with the criteria for taking the survey and then given the link to the survey. The diversity of the group comes through the identified

14

denominations of the participants, and the email encouraged participants to forward the

information to as many people as possible in order to achieve a group with the largest range of

diversity.

Participants were screened through the first question of the survey. They were asked to

respond yes or no to the question "Are you a designated leader in a church that identifies itself as

Christian?" If the answer was no, the survey's question logic was set up to thank them and let

them know that, unfortunately, they did not meet the qualifications for the survey. If the answer

was yes, the respondent immediately entered the survey's Informed Consent segment, and if

agreeing to continue, answered the questions beginning with demographic information.

Data Collection Methods

Demographic information that was collected includes: age, gender, race/ethnicity,

identified denomination within the Christian church, amount/type of education post-high school,

position within church, length of time in paid ministry, and number of congregants within the

church served by the respondent. The quantitative information for this study was collected, as

noted above, through an online survey. The survey utilized multiple choice, yes/no, and some

open ended questions followed by comment or dialogue boxes provided for participants who

elected to elaborate on their responses to the questions asked.

At the end of the survey, contact information for the researcher was provided for those

respondents who wished to participate in a recorded face to face or phone follow-up interview.

This interview provided for the collection of at least some limited qualitative data from five or

six participants, and gave agency to all individuals responding to determine the depth of their

participation in the study. Individuals were informed that the interview would last approximately

30 minutes and that they would be asked to discuss their beliefs regarding types of mental health treatment. Interviews were audio recorded.

All personal information from participants in the survey questions only was encrypted by Survey Monkey and not made available to the researcher. Any identifying information disclosed in the interview or dialogue boxes within the survey was kept confidential by this researcher, and disguised in quotations used in the thesis report or other disseminations. The internet survey provider employed allowed for respondents to complete the quantitative survey anonymously, thus ensuring protection of personal information.

This survey and interview process has given leaders another opportunity to review and discuss their own personal and spiritual views on the nature and treatment of mental health and substance abuse issues. This experience allowed them to share an experience they have had working with those in their faith community, and ideally, a chance to process differences in opinions they may have about the process of helping within their community.

Participants were told in the email they received, as well as in the informed consent information they received at the beginning of the survey, that participation was voluntary and they were free to end their participation at any time until they submitted their survey. After the survey was submitted, due to the anonymous nature of the survey, there was no way to identify what information had been given by any particular respondent. Through the informed consent information, participants were also informed about the potential benefits and risks of taking part in the survey. Participants in the survey were told that their entry into the survey signified their informed consent to take part in the survey.

Informed consent for the interview was obtained prior to the interview, either by having the participants sign a form as the interviews were beginning, or by faxing it to the participants

and having them fax or scan it and email it back if they were in different geographic regions from the researcher so that the interviews could not be conducted face to face.

Information collected after the survey and during the interview were assigned code numbers known only to this researcher in order to ensure confidentiality. Signed informed consent forms are being kept in a separate secure location from the interview materials and transcripts.

Leaders were asked not to use real names of congregants or divulge any identifying information about those they serve, other than basic demographic information, in order to protect the identities of those they are working with.

Although it was not the intention of the researcher, it may be possible that leaders who took the survey and/or participated in the interview may have recalled a situation they were asked to help with in which they did not provide support in the same way they would have if they were to address the same situation at the time of the interview. This may have caused them to wish that they had dealt with the situation differently, and make them uncomfortable. This was a potential risk of participation; however, those who are identified leaders within their churches are likely to be aware of resources in their locations, and to understand how to obtain help in dealing with uncomfortable situations. As the role within many churches is for the leaders to help access support during a time of crisis, this group of people would have the information needed to meet their needs if they were to struggle with a question asked in this survey. Due to the nature of the research question -- to identify the extent to which spiritual counselors utilize mental health referrals for their congregants -- providing them a list of mental health referrals might also have carried a risk of tending to bias their responses to some of the questions in the survey.

Data Analysis

Due to the small scale of this project, and the individual views on various theological topics within individual denominations, the quantitative data involve only limited inferential statistics, mainly to correlate information such as formalized mental health training and a tendency to refer to treatment. Most quantitative data are simply descriptive of the population from which they were gleaned. Data were gathered through the online survey program chosen, exported to the researcher in an Excel file, and analysis was further supported by efforts of the researcher as well as those of the Smith College statistical analyst.

The qualitative data for this project were collected through the interview process and then completely transcribed. Themes were then collected and manually content-theme analyzed to draw additional conclusions regarding opinions and actions of leaders. All interview data were transcribed by the researcher.

Anonymity was naturally occurring for those who chose to take part in the online survey, as no specific identifying information, such as name or location, was collected. Those who chose to be part of the follow up interview process were assured that the researcher would keep their information confidential and change any identifying information when discussing their answers in the thesis report or other dissemination activities.

As the researcher is a student, the research advisor had access to the raw data after all identifying information was removed, in order to assist with analysis and writing the thesis report. During dissemination of the research, all identifying data were removed or changed, and most data have been presented in terms of groups of people rather than individuals.

Data and tapes have been stored in a secure location and will be retained for three years as required by Federal regulations and will be destroyed at that time if no longer needed for

future research. If still needed, all data will continue to be kept in a secure locked location. All electronic files will be encrypted and stored to protect them.

Participation in this study was completely voluntary, and participants were free to withdraw at any time until they submitted the survey; they were also able to refuse to answer any single question without leaving the survey as a whole. Those participating in the face to face interviews were able to choose to have their information removed from the study within 48 hours after the interview. If a participant chose to withdraw from the interview portion of the study, all information collected about that individual was immediately destroyed.

CHAPTER IV

Findings

Introduction

The sample for this study was obtained through snowball sampling of my colleagues. Fifty-eight people responded to the recruitment email that was distributed. There were a number of respondents (15) who answered the initial screening question but did not finish the survey. Four of those 15 answered the screening question "Are you a designated leader in a Christian Church?" with "no," and were thereby excluded. The other 11 answered the screening question with "yes," but did not complete any other questions in the survey for unknown reasons. Forty-three people answered the initial screening question with "yes" and answered one or more of the remaining questions in the survey. Except where noted, results and percentages provided here are based on the answers of the 43 people who completed the survey.   As the minimum number of respondents for a study involving parametric statistics is at least 50, it is difficult to correlate the expressed beliefs and the demographics of any given subgroup within the leadership of the Christian Churches represented in this survey. Also, as there are many groups that are not represented in this sample, any conclusions drawn are based on these specific respondents, and are not necessarily generalizable to Christian leaders as a whole.

At the end of the survey an opportunity was given for respondents to participate in a follow up interview. Four people chose to participate in the interview process. To protect their

confidentiality, they have each been assigned pseudonyms that will be used for the discussion of their answers.

- Adam, Caucasian, Male

- Bill, Caucasian, Male

- Chelsea, Caucasian, Female

- Dan, Caucasian, Male

Demographics

Respondents were asked to complete demographic information. As each of the survey questions was optional, not everyone chose to answer each question. In order to accurately characterize the sample, the percentages in each category reflect the number of responses out of 43, and not the number that completed the question.

Age. Ages reported ranged from 23 to 78, with the largest number of respondents reporting that they were between 31 and 40 years of age (10), and the lowest being 60 and over (6).
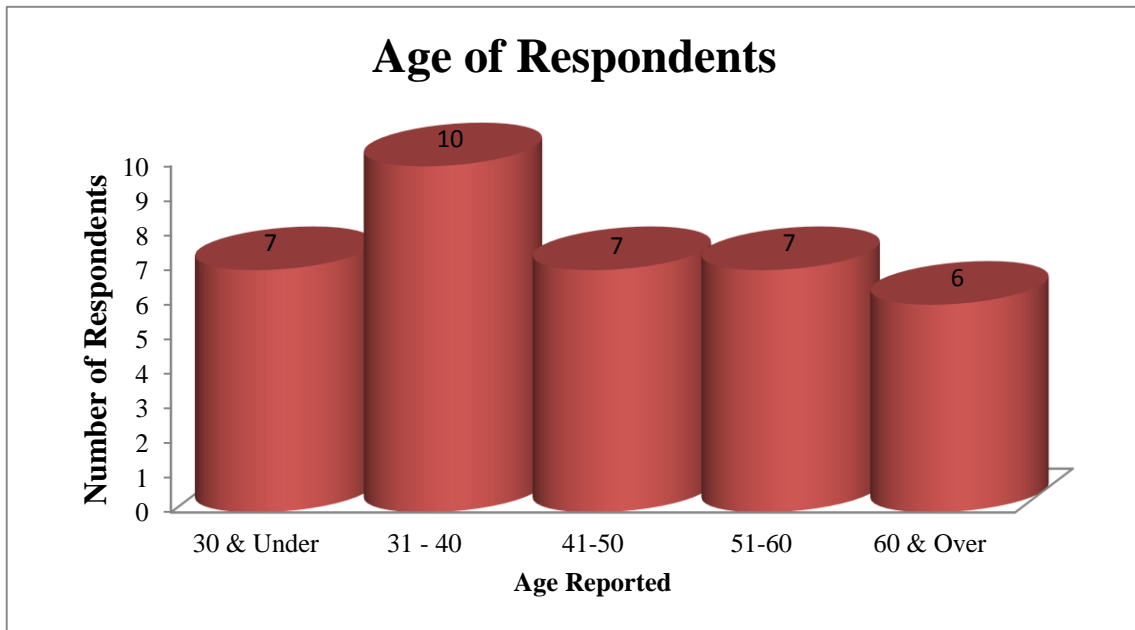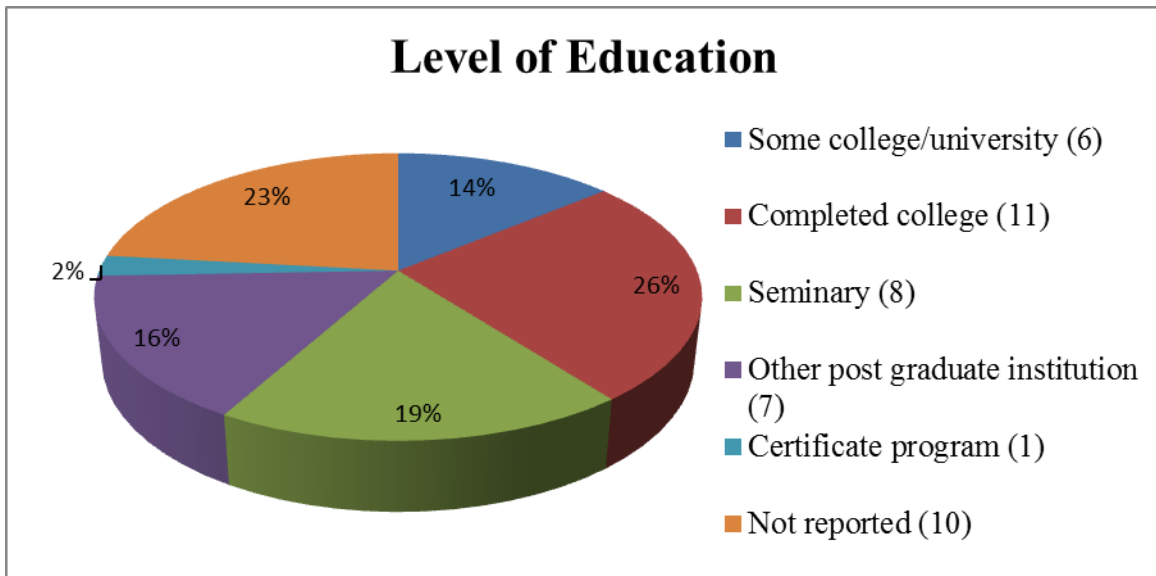
Gender. Thirty-five percent of respondents (15) reported that they identified as female and 51% (22) as male. Six people chose not to report their gender.

Race/ethnicity. Eighty-six percent (37) of respondents reported identifying as Caucasian or White. Fourteen percent (6) did not report.

Number of years in leadership. Respondents were asked to identify the number of years they had been in leadership within the church in general, not just the churches in which they were currently serving. More than half of respondents (22) reported being in leadership for more than seven years, with eight reporting having been in leadership for at least 20 years.
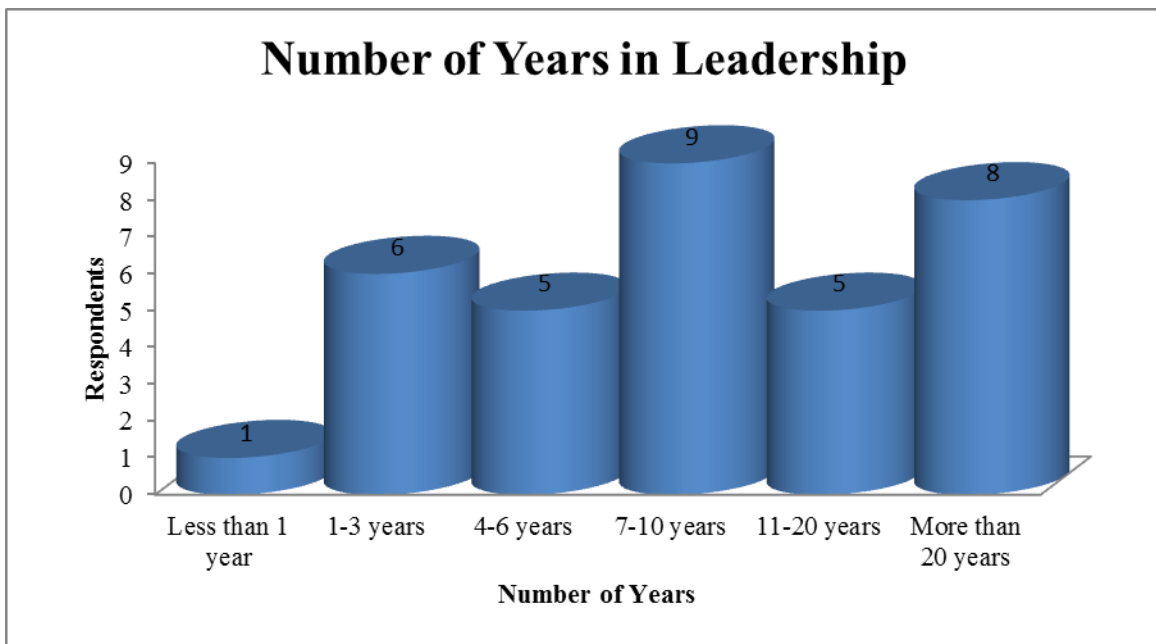
Education. A majority of respondents (26) reported completing college or higher, with 45% (15) stating that they had completed either seminary or another postgraduate institution, and three individuals have completed at least two post-graduate degrees, including Master of Divinity, Master of Education, Master of Social Work and Ph.D.

Level of Education

- Some college/university (6) — 14%
- Completed college (11) — 26%
- Seminary (8) — 19%
- Other post graduate institution (7) — 16%
- Certificate program (1) — 2%
- Not reported (10) — 23%

Respondents were asked to identify if they had completed any formalized training to be in leadership within the Christian Church. Twelve individuals stated that they had no formal training, while 21 reported taking courses in such areas as working with church youth, parish nurse training, mentorship, and pastoral ministry.

When asked, 32% (14) of respondents stated that they had formal training in mental health or addiction issues. They reported a range of trainings, including classes for obtaining a Master of Social Work degree, college classes in Psychology, Certified Drug and Alcohol counselor trainings, and one respondent reported having been trained as a psychiatric nurse.

Types of Churches Represented

Participants were asked to name the denomination of Christian Church they were serving in. In alphabetical order, identified denominations were: Baptist (2), Catholic (5), Christian Science (1), Church of Jesus Christ of Latter-day Saints (1), Episcopal (1), Evangelical Free (1), Four Square Pentecostal (1), Non-denominational (12), Presbyterian (1), Roman Catholic (5), United Church of Christ (2), and United Methodist (1). Ten respondents chose not to identify their denomination.

Roles and Responsibilities

Respondents were asked to identify any populations they were in charge of leading. Thirty-five percent (15) reported working with children, 37% (16) with youth, 30% (13) with men, 35% (15) with women, and 23% (10) with seniors. Other populations included inmates in a local jail, a religiously affiliated program center, and missions on a global and local level.

Respondents were then asked to identify the primary responsibilities of their role. Fifty-three percent (23) identified preaching or teaching, 56% (24) identified counseling or spiritual guidance, 56% (24) identified event planning and coordination, and 49% (21) identified coordinating volunteers. Other responsibilities included making financial decisions, managing staff, leading groups, musical responsibilities, leading mission trips, and community service.

Number of People Attending Representative Churches Weekly

In order to better understand how many people are impacted by the leaders who participated in this survey, each leader was asked to report the average number of people who attend in any given week. Twenty-three percent (10) chose not to respond. Nine percent (4) said less than 25; 5% (2) said 26-50; 12% (5) said 101-200; 5% (2) said 201 – 300; 12% (5) said 301-500; 2% (1) said 501 – 700; 9% (4) said 701-1000, and 23% (10) reported that more than 1000 people attend their church on any given week. As the sampling for this survey was done anonymously, there is no way of knowing how many individual churches are represented by these numbers because multiple leaders from the same church may have responded.

Leaders were asked to identify how often they were approached to meet individually with someone regarding a life issue. The two most common answers were 1-3 times per week (15, or 35%) and 1-3 times per month (15, or 35%). Twenty-six percent (11) reported that they are approached less than 1 time per month, 1 person reported being approached 4-6 times per week,

and 1 person reported speaking with someone more than 1 time per day. The number of

attendees of the individual church did not appear to strongly correlate with the number of times

per month a leader was approached to meet individually. Of the 10 people who reported their

church had an average attendance of 1000 or more, half (5) reported that they were approached

less than one time per week to meet with an individual, while half (2) of the individuals (4) who

reported less than 25 people in their church attend weekly stated that they were approached at

least one time per week to meet individually.

Mental Health Issues

  Individual meetings. Respondents were asked what percentage of individual meetings

they held had to do with a participant's emotional state. The category with the largest number of

responses (12) was that 51-75% of the time leaders were discussing emotions such as anger, joy,

sadness, or fear. Close behind that with ten responses was 25-50% of the time. Seven (16%)

respondents stated that more than 90 percent of their meetings are spent discussing emotions, and

six (14%) state that they spend less than 10% of their individual meetings talking with people

about emotional responses.

  Causes of mental health problems. The first question asked of the four interviewees

was what their views of the causes of mental health issues are. Three discussed their views that

there is no one thing that creates a mental health problem.

  Dan stated that in the past he had worked with some denominations that "tended to

attribute a lot more things to demons," but that was not his belief about the causes, which he said

tended to be more that problems could be the result of many things, such as "chemical

imbalances" or a defense mechanism against some type of a loss. Similarly, Chelsea discussed

her view that "mental health problems can have a variety of different influences and…that there

might be different contributing factors for each individual," which she stated included chemical imbalances, physical, physiological, environmental, emotional and spiritual causes.   Bill's views were similar to Chelsea's and Dan's, and he also stated that his religious views did not necessarily impact his beliefs about mental health, but that "they are in harmony with one another."

Adam, however, stated that he believes that "problems in mental health come down to a sense of feeling separated from God, oftentimes I think it comes down to focus on oneself and getting very involved in the problems of self." This separation from God can be a result of "not feeling connected to community," when "life is causing them to grow and they don't know how," or that someone is receiving a message over and over in his or her life of being "worthless or not useful." He also stated that "it would be better for everyone to see all [problems] as spiritual issues."

Suggested interventions. In the online survey, leaders were asked to identify the types of interventions they may suggest for those they speak with regarding emotional issues. Interventions suggested by the survey included prayer, referral for continuing meetings with the leader, group (AA/NA/etc.), scripture readings, and referrals to mental health professionals for individual counseling or to psychiatrists for medications. Interviewees were also given space to elaborate on their responses.

As seen from the chart below, participants overall stated that they were likely to, or would typically recommend, prayer (74%) and scripture readings (75%). In the follow up interviews, each of the four was asked if they had particular scriptures that they referred to more often than not. Most responded that they did not have specific scriptures, that their recommendations were dependent on the situation; they said they would typically look to verses

that referenced God's love and the examples in the Bible of God's redemption. Bill stated that he would probably refer to Psalm 139 "that there's nothing in our lives that God can't handle," Psalm 23 "about the Lord being my shepherd, guiding me through," and Psalm 25 "a prayer about being alone and afflicted and having no one but Him."

	Respondents' Probability of Recommending Various Interventions for Emotional/Mental Health Issues			
	Would Not Recommend	Not Likely to Recommend	Likely to Recommend	Typically Recommend
Group Meetings	2% (1)	16% (7)	**42% (18)**	14% (6)
Ongoing individual counseling with leader	7% (3)	30% (13)	**44% (19)**	2% (1)
Prayer	0% (0)	2% (1)	23% (10)	**51% (22)**
Referral to Mental Health Professional	0% (0)	7% (3)	**42% (18)**	26% (11)
Referral to Psychiatrist	2% (1)	30% (13)	**33% (14)**	12% (5)
Scripture Readings	2% (1)	16% (7)	35% (15)	**40% (17)**

The next most likely intervention to be offered was follow up with a mental health professional, with 68% (29) stating they were likely to recommend or would typically recommend a referral. More than half of survey respondents (56% or 24) were at least likely to recommend group meetings, and ongoing counseling with the leader (46% or 20 respondents) and a referral to a psychiatrist (45% or 19 respondents) would be similarly recommended by this group.

Only 7% (3) of respondents would not recommend ongoing individual counseling with the leader and 2% (1) of respondents would not recommend group meetings, a referral to a psychiatrist, or scripture readings.

A number of leaders remarked in the comments section of the question that they were hesitant to choose a category such as "typically recommend" as it was preferable for them to take each case individually and their recommendations would most likely have been based on the

needs of the person they were meeting with rather than treating everyone the same. As one survey respondent noted,

> Most of this depends on the situation and what the person is going through. Anger, frustration, etc. are all symptoms of a deeper problem and are merely the fruit of what is really going on. My job is to get beneath the symptoms and figure out the root of the issue and then treat that accordingly.

Responses of participants with/without formal mental health training. In comparing the interventions recommended with whether or not the leader taking the survey had received formal mental health training, the following results were obtained. Those who identified that they had studied mental health in some way were more likely to recommend group meetings (88% of those who identified having training vs. 67% of those who identified as having no training), ongoing individual counseling (71% vs. 39%), and prayer (100% vs. 93%) as interventions for emotional issues. Those who had not studied any type of mental health issues were more likely to recommend a referral to a psychiatrist (55% vs. 50%) and scripture readings (80% vs. 71%) as interventions. The percentages of individuals who would recommend a referral to a mental health professional were equal for both groups (92%). Those who had studied mental health were slightly more likely (69% vs. 67%) to provide a list of recommended mental health professionals to the congregant needing assistance, and were also slightly more likely (39% vs. 38%) to recommend that the professional identify as a Christian in their practice.

Substance Abuse or Other Addictions

Individual meetings. Of the individual meetings that occur, participants were asked to quantify the percentage that involved speaking with someone about any type of substance abuse or addiction issues. Twenty respondents (47%) reported that less than 10% of their meetings are

about this topic. Ten (23%) said 10-25% of their meetings, nine (21%) reported 26-50%, three (7%) reported 51-75%, and one (2%) reported 76-90%.

Causes of substance abuse or addictions. During the individual interviews, Chelsea discussed her observation that people who "struggle with addiction also struggle with control, and [they] either have too much control forced on them or have no control in their environment." Her view was that the addiction starts when people are able to find something that they feel they can have control over, and that "some of [those things] can be detrimental." She continued by saying that she wasn't sure about the idea of an "addictive personality," but recognized that some people seem to be more prone to addictions than others.

Adam stated that "the truth about addiction is that it is what we do when we feel unsatisfied and we want to feel satisfied." His "feeling is that a greater understanding of the fact… that when we are satisfied by spiritual things…we can move forward without that longing or that feeling of being ruled or owned by a thing, whether it be drugs or whatever."

Bill's response was that "sometimes we do things to make our anxieties go down, or to do things to help us escape," and that it is important for those who are dealing with drug use to analyze their relationships to those substances and determine whether it is ruling their lives, or whether they are able to function while using.

Suggested interventions. As with the question regarding interventions for emotional issues, participants were asked to rank how likely they were to use the interventions of group meetings, individual meetings with the leader, prayer, referral to mental health professional, referral to psychiatrist and scripture readings. There were fewer respondents to this question than there were for the same question regarding the probability of recommended interventions for mental health or emotional issues.

The chart below shows that leaders are likely to or would typically recommend group meetings (60% or 26 respondents), prayer (63% or 27 respondents) and scripture readings (63% or 27 respondents) as the primary interventions. A referral to a mental health professional would potentially be recommended by 61% (26), and a referral by a psychiatrist by 40% (19).

	Respondents' Probability of Recommending Various Interventions for Addiction Issues			
	Would Not Recommend	Not Likely to Recommend	Likely to Recommend	Typically Recommend
Group Meetings	2% (1)	5% (2)	23% (10)	**37% (16)**
Ongoing individual counseling with leader	7% (3)	**33% (14)**	28% (12)	5% (2)
Prayer	0% (0)	7% (3)	14% (6)	**49% (21)**
Referral to Mental Health Professional	0% (0)	7% (3)	**35% (15)**	26% (11)
Referral to Psychiatrist	2% (1)	30% (13)	**28% (14)**	12% (5)
Scripture Readings	2% (1)	12% (5)	30% (13)	**33% (14)**

Overall, respondents stated that they were not likely to or would not recommend ongoing individual counseling with the leader (40% or 17 respondents). A smaller percentage are not likely to or would not recommend group meetings (7% or 3 respondents), prayer (7% or 3 respondents), a referral to a mental health professional (7% or 3 respondents), and scripture readings (14% or 6 respondents).

Formal mental health training. Again, the types of recommendations that would be made were compared between the group who identified having formal mental health training and the group who identified not having had mental health training. Those who stated that they had received some type of training were more likely to recommend some type of group treatment such as Alcoholics Anonymous (100% of those who identified having mental health training to 92% of those who identified having no mental health training), and more likely to recommend ongoing individual meetings with the leader (54% to 33%). Those who identified having no

30

formal training were more likely to offer prayer (92% to 82%), a referral to a mental health professional (92% to 90%), a referral to a psychiatrist (64% to 42%), and scripture readings (77% to 75%).

Ongoing training for Christian church leaders. During the follow up interview, the four participants were asked to discuss what, if any, trainings or follow up education they would recommend in the area of mental health or addiction issues.

Dan's response was instantaneous. He wanted to tell a story, and started it with "This is how I learned empathy, which I think is the biggest thing that clergy need to learn so that they can be able to learn more about what you just asked." He then related a story of coming into a new position and working with an individual who believed that she was being electrocuted at night so that she would tell her secrets to the government. After doing some research, he discovered that she had two box springs instead of a box spring and mattress, and that in the night the heater would heat up the wires running through the box spring and she would feel the heat of the wires. He then said

> I would tell my brother and sister clergy that if we really want to take care of people, and we really want to bring them closer to God, then no matter what the situation is, we have to really listen and enter into their world, and sometimes in order to do that we need a basic psych course or an abnormal psych course.

In contrast, Adam stated that he didn't feel the need for training. He felt that his knowledge in how to help those with mental health and addiction issues was "primarily based on experience, some classes here and there, but mostly experience in my own live, my prayer life, and my experience in spiritual counseling with others." His "practice is that the more I see these

rules operating in my own life, the more I can teach them and help others experience them in their own lives with authority and conviction."

Chelsea also talked about how her own experience informed her views about additional training for church leaders. "I think my knowledge comes from the experience of others and answering questions. That's the type of person I am. To ask questions and seek answers." Her desire was for a way to talk with people who have mental health and addiction issues in a way that was supportive and understanding. She believed that she and other leaders would benefit from learning ways to identify what potential warning signs of problems are, and how they could locate the resources in the community that could be used by those who are struggling.

Bill discussed his formal training in social work as well as his education in religion and ministry. He emphasized the importance of recognizing that the issues that people are dealing with often have a spiritual side as well as a biological or physiological component, and that it is important for leaders to be able to recognize the impact that each may have on the problem.

CHAPTER V

Discussion

My interest in the research for this thesis began with the experience related in the first chapter with the client I called Crystal. She was devastated when her church pastor told her that her problem was only because she wasn't praying enough, and that she needed to try harder to be a good Christian. Crystal believed she was trying her hardest and she believed she needed medication and therapy to help her. My goal was to help those who were in the same situation as Crystal, torn between the values of her faith community and her belief that she was truly able to get better if she had supports in addition to prayer and scripture. I believed that it would be essential for mental health professionals to understand how church leaders understand and support those who come to them with mental health and addiction issues. This study was designed as a beginning effort towards collecting that information.

Strengths and Limitations of the Study

The main method of collecting information was through an anonymous survey on the internet. Participants were encouraged not to share any identifying information, other than basic demographics, about themselves or those they were supporting, which allowed for respondents to provide honest answers. The limitation to this method of collection was the lack of ability to answer any questions that the respondents had about the survey unless they chose to email and ask. It also did not allow for asking follow up or clarifying questions about answers received.

The other portion of data was collected through individual interviews with leaders who chose to respond to a request for further participation at the end of the survey. Information collected in these interviews was helpful for allowing clarifying questions from the researcher as well as the interviewee. This process allowed for the respondent to give greater detail on any information they had provided in the survey. It also allowed the researcher to present scenarios and ask more specific questions about the way the individual leader's' beliefs about the causes of mental illness and addiction influenced the ways they offered support to those in need.

Although much can be learned from the information disclosed by participants in this study, there are several limitations to be explored and understood before utilizing the data. The first limitation of this study is the number of participants. As there were 43 participants who finished the survey online, and four of those chose to move on to the interview section, it can hardly be said that these few represent all people who identify as Christian leaders.

In reviewing the demographic information from this study, a number of pieces were different than had been hypothesized initially. Originally, it was expected to be much easier to obtain a larger number of respondents. The method of recruiting subjects through snowball sampling was effective in collecting this small sample; however, in a future study, a more large scale way of recruiting candidates, such as through mailing lists or internet groups might be more effective.

One of the strengths of this study is the number and variety of Christian denominations represented by the respondents. Although these leaders did not present themselves as speaking for their identified denomination, it is more likely at least an indicator of the views of mental health and addiction of a certain subgroup, especially those that had a proportionately larger number of participants than the others.

A limitation of this study is the apparent lack of racial diversity among the participants. Although not all respondents chose to identify their race or ethnicity, virtually all of those who did reported that they identified as "white or Caucasian." There are a number of issues in having such a narrow sample, including the potential omission of views of leaders who belong to denominations of Christianity that have historically been made up mostly of individuals who identify as members of other ethnic or racial groups.

Implications for Treatment and Practice

The information collected by this study was more encouraging than had been expected. Originally, it was my hypothesis that a majority of leaders would primarily recommend prayer and scripture readings as the main interventions for those who were struggling. As the results unfolded and information was analyzed, it became clear that while there were a number of leaders who recommended prayer and scripture readings, most leaders acknowledged the additional need for further interventions and the assistance that can be provided by professional mental health counselors.

It was also encouraging to note that a number of these leaders acknowledged that if they felt that an issue required interventions they were not equipped to provide, they would make referrals to professionals and then would continue to help as they were able. As Chelsea said, "I see my role as a minister…of a church, not a…counselor. That doesn't mean I can't be a support and provide that extra encouragement."

I was also pleased to note the amount of empathy and understanding that was expressed by those who took the survey. Those who participated in the follow up interviews did not paint the person struggling with mental health or addiction as a "bad person." The overwhelming view presented by those who participated in the survey and the interviews seemed to be that the person

35

who was struggling was having a problem that had a cause and a solution, and that the job of the leader was to help determine what would be the most helpful. Although the methods of sorting out the issue were very different, there did not appear to be an attitude of the person's deserving what was happening to them --, only empathy toward the struggling and a desire to assist.

It was concerning for me to note that there were leaders who stated they were not likely to or would not recommend prayer or scripture readings when working with these issues. Although addiction and mental health issues are certainly present in those outside the Christian Church, as was observed earlier in this research, addiction and mental health issues are certainly impacted by spirituality and vice versa. With this understanding, it would be important for church leaders to offer prayer and scripture as supports while the person is struggling. As I am not able to follow up with those who participated in the anonymous portion of the survey, I am not sure if they were stating that they were not likely to recommend those interventions at all, or if they would not recommend them as the only interventions for this type of problem.

The information received in this study emphasizes the importance of mental health providers being aware of the views of Church leaders about how mental illness and addiction are acknowledged and treated within an individual's church. As with offering any type of intervention, it is necessary for the mental health provider to assess how the individual understands the problem he or she is experiencing before offering support and potential solutions. It should be a regular part of practice to understand not only how the person served understands the problem, but also how those who are in the person's community may perceive what he or she is dealing with. It is essential to remember that no person lives completely without the influence from and interaction with others, and that there are a number of outside experiences and relationships that impacting the lives of those seeking help. Although it is

possible for professionals to assist someone in recognizing the issues in conversation, ultimately the ability to make change is dependent on supports outside of the therapeutic alliance that understand and encourage treatment. Mental health providers need to understand the influence of these supports and should be able to help individual congregants discover how others' views are helpful or harmful to healing and recovery.

Ultimately, improving relationships between mental health professionals and Christian leaders can only be helpful. Since there is no objective test for a majority of mental health issues, professionals must rely on what the person seeking help is reporting as well as the subjective views of the important people in his or her life. This requires collaboration on the part of the leader as well as the mental health professional, as well as an understanding on the part of the person seeking help regarding how the information would be shared. On a larger level, continued understanding between those who provide spiritual leadership and those who provide mental health services will continue to improve the supports available to those who are suffering. The topic of how spirituality and mental health interact is so large that there is no way for every mental health practitioner and Christian leader to understand all of the potential causes, risk factors, and triggers for each issue. As leaders and professionals are able to interact on a larger level, we can increase the knowledge that each has, and will be able to offer feedback, solutions, and dialogue about problems and potential solutions.

Suggested Areas for Further Research

There are several areas that should be further explored in order to continue to assist mental health providers in working with individuals who identify as Christian. The first is the impact that leaders' views of the issue of free will versus determinism have on the ways that they understand and address the needs of their congregants. Throughout the history of both

Christianity and other world religions, views as to how much free will any individual soul has have varied widely. Some have viewed salvation as predestined, while others clearly hold that salvation is the result of faith or good works. Such varying views would most likely have some influence on leaders' thoughts about the value of interventions such as prayer and scripture readings on the treatment of mental health and addiction issues, as well as the potential that someone would be helped by seeking treatment from a mental health professional.

Additionally, it will be important to understand how the views of leaders in the Christian Church towards mental health and addiction issues change over time. Is it the experience that they have working with the people in their church, research that is done by the mental health community, a part of their own spiritual growth, or perhaps a product of all three? The more that we understand what it is that is a catalyst for change in the views toward these issues, it will be easier to partner with leaders in the treating of the individuals who are suffering.

Another area to continue to explore is the interest on the part of mental health professionals and Christian leaders in working together on these types of issues. It is likely that those who believe these problems to be solely based in spiritual matters would not be interested in having these conversations or working with mental health professionals. It is also likely that mental health professionals who believe these issues to be separate from spiritual issues would struggle with the idea of bringing a Christian leader into the circle of influence for someone asking for help. Only when people actually want to be a part of the conversation will this be helpful, so finding those who believe that these issues are impacted by all aspects of a person's life will be key to starting to bridge this gap.

Conclusion

At the end of each follow up interview, I gave interviewees the chance to express anything about their views of the help that the Christian Church offers to those who are struggling with mental health or addiction. Dan's response was

I think it stinks. I do not think that enough clergy take it seriously. I'm very frustrated that I think it scares people. The [leaders]. I think that [leaders] have a tendency to try to put a Band-Aid on things and try to rush people away as opposed to really taking time to enter their work and accompany them. I think the [leaders] that are willing to study social work or any of the helping professions are few and far between and many of [those who don't] get stuck in "I know all the answers because I studied theology" and I really think that, although I studied theology, that's not only it. It doesn't work for everybody and you have to really have an understanding of what happens with people. Religion can be a wonderful thing for folks, but it can also be really terrible for folks. I think that with some of the situations that people find themselves in, religion becomes a burden that isn't healing, if anything it's more persecution that's heaped upon them. And I really wish more [leaders] would take more time to enter into the world of the people they're supposed to be serving.

During His earthly ministry, Jesus stated that he came so that those who followed Him may "have life more abundantly" (John 10:10*).* He showed nothing but compassion to those who were suffering and offered them healing and restoration. If the Christian church is truly trying to model the message of Christ to everyone, then the idea of meeting someone in their pain is not only necessary, but expected. I am encouraged that, overall, those who participated in this

39

survey seem to understand that. With increased understanding of the causes and effective

treatment of mental health and addiction issues, Christian leaders and mental health professionals

will be able to support each other as we help the whole person.

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Appendix A

Human Subjects Review Committee Approval for Study

January 1, 2012

Katryn Little

Dear Katryn,

You are officially approved to continue your study and I hope you follow up with me when you are done and let me know how it went.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Best of luck with your research. Happy New Year.

Sincerely,

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Gael McCarthy, Research Advisor

Appendix B

Recruitment Email

This is the email that was sent to my colleagues to ask for their help recruiting Christian Church leaders to participate in my survey.

Dear colleague –

Will you please help me find participants for my Master's in Social Work thesis survey? I am researching the attitudes and beliefs that Christian Church leaders have about mental health/addiction causes and treatments. I am looking for self identified designated adult leaders in churches that identify as Christian to take 15-20 minutes to answer my 17 question survey. Could you please pass this along to anyone who would be interested? The link to the survey is: (insert link to survey)

Thank you so much for your time and help!

Katryn Little

MSW Student

Smith College School for Social Work

Appendix C

Survey Monkey Survey and Informed Consent

Informed Consent

My name is Katryn Little. I am a second year Master's degree student at Smith College School for Social Work. I am conducting a study of the views about mental health problems and substance abuse issues that are held by designated leaders in Christian churches. The research I gather in this study will be used as a part of my MSW thesis and in possible future professional or public presentations and publications.

If you identify as a designated leader in a church that identifies as Christian, I would like to ask you to participate in a survey about your experiences in working with people in your church who may have mental health problems or are dealing with their use of drugs or alcohol. The survey takes approximately 15 to 20 minutes to complete. At the end of the survey, you will be given the option to contact me if you are willing to participate in a brief, but more in-depth follow up interview. This interview may be face to face or over the phone or via the internet (in Skype, gchat, etc.) -- whatever is most convenient given your geographic location or personal preference. The interview would be audio recorded, and I will be transcribing the interview from the recording.

It is my hope that you will be able to benefit from this study through a discussion of the various views of the causes of mental health and substance abuse issues. It is possible that through this process you may recall a situation that you wish you had handled in a different manner, and might experience distress as a result. If this should occur, I urge you to utilize the resources that you would recommend others use. I am not able to offer compensation for your participation in the study beyond thanks for your time and willingness to help supply information about improving the lives of those you lead.

As noted, the online survey portion of this study allows all information to be given anonymously. I will have no way of knowing who you are unless you choose to give that information in the comment boxes after one of the questions, and I encourage you to provide no identifying information in such comments. My research advisor will have access to the data collected, but will not receive any identifying information about anyone who chooses to participate. All data collected through this study will be saved for a period of at least three years in a secure location as required by federal guidelines. Electronic data will be encrypted and stored. All information will be destroyed after three years, or if needed beyond three years, retained in its secure location. Your participation in this study is completely voluntary. You may choose to withdraw from the study at any point, and you may refuse to answer any question. Information may be changed or deleted until you submit the survey. Due to the nature of the online survey, it is not possible to to change or remove your answers from the data after you have entered it into the survey, as I will have no way of knowing which responses belong to a particular participant. If you have any concerns about your rights or about any aspect of the study, please contact me at klittle@smith.edu or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Informed Consent - Continued

FOR ONLINE SURVEY PARTICIPANTS, YOUR ENTRY INTO AND COMPLETION OF THE SURVEY DOCUMENTS THAT YOU HAVE UNDERSTOOD THE PURPOSES OF THE STUDY AND YOUR RIGHTS AS A PARTICIPANT, AND THAT YOU AGREE TO PARTICIPATE. Please print a copy of this consent for your records.

Thank you for your participation in this study.

Question 1

1. Are you a designated leader in a church that identifies as Christian? (Please choose one.)

○ Yes

○ No

Individual Meetings

2. On average, how often are you approached by a congregant to meet individually regarding a problem in his/her life? (Please choose one.)

○ Less than 1 time per month

○ 1-3 times per month

○ 1-3 times per week

○ 4-6 times per week

○ 1 time per day

○ More than 1 time per day

3. What percentage of the individual meetings that you have involve talking about emotional states, for example sadness, anger, joy, fear? (Please choose one.)

○ Less than 10%

○ 10 - 25%

○ 26 - 50%

○ 51 - 75%

○ 76 - 90%

○ More than 90%

4. What percentage of the individual meetings that you have involve discussion about substance use or other addiction (internet, gambling, pornography, etc.)? (Please choose one.)

○ Less than 10%

○ 10 - 25%

○ 26 - 50%

○ 51 - 75%

○ 76 - 90%

○ More than 90%

Emotional Difficulties

5. How likely are you to recommend each of the following interventions to one of your congregants who approaches you with emotional struggles that appear to be impacting the person's quality of life (for example, problems dealing with anger, frustration regarding life situations, grief, etc.)? (Please choose all that apply.)

	Would not recommend	Not likely to recommend	Likely to recommend	Typically recommend
Prayer	○	○	○	○
Scripture Readings	○	○	○	○
Group Meetings (AA, NA, etc.)	○	○	○	○
Ongoing individual counseling with you	○	○	○	○
Referral to mental health professional (social worker, therapist, etc.)	○	○	○	○
Referral to psychiatrist	○	○	○	○

Additional Information

Substance Use and Addiction

6. How likely are you to recommend each of the following interventions to one of your congregants who approaches you with problems with substance use or other addiction? (Please choose all that apply.)

	Would not recommend	Not likely to recommend	Likely to recommend	Typically recommend
Prayer	○	○	○	○
Scripture Readings	○	○	○	○
Group Meetings (AA, NA, etc.)	○	○	○	○
Ongoing individual meetings with you	○	○	○	○
Referral to Mental Health Professional (social worker, therapist, etc.)	○	○	○	○
Referral to Psychiatrist	○	○	○	○

Additional Information

Mental Health Professionals

7. If you recommend that someone see a mental health professional or psychiatrist, do you provide names of suggested professionals? (Please choose one.)

○ Yes

○ No

○ Don't recommend

Other (please specify)

8. If you recommend that someone seek help from a mental health professional or psychiatrist, how often do you recommend that the professional identify as Christian? (Please choose one.)

○ Greater than 90%

○ 51-90%

○ 10-50%

○ Less than 10%

○ It does not matter

○ I do not recommend mental health or psychiatry

Other (please specify)

Demographic Information

In order for me to be able to accurately characterize the diversity of my sample, please take a moment to complete the following information about yourself, if you are willing to provide it.

9. Please identify your age grouping

[▶]

10. What is your gender? (Please choose one.)

○ Female

○ Male

○ Other

11. Please identify your race/ethnicity. (Please choose the most applicable.)

[   ]

Demographic Information – Continued

12. How long have you been in church leadership (not necessarily in the church you currently serve)? (Please choose one.)

○ Less than 1 year

○ 1-3 years

○ 4-6 years

○ 7-10 years

○ 11-20 years

○ More than 20 years

13. Please choose the answer that best describes your post-high school education. (Please choose one.)

○ Some college/university

○ Completed college

○ Seminary

○ Other post-graduate institution

○ Certificate program

Other (please specify)

14. What is the denomination of the church in which you currently serve?

15. How many people attend the church in which you currently serve? (Please choose one.)

○ Less than 50

○ 51-100

○ 101-200

○ 201-300

○ 301-500

○ 501-700

○ 701-1000

○ More than 1000

16. Which groups within your church are you part of leading? (Choose as many as apply)

☐ Children

☐ Youth

☐ Men

☐ Women

☐ Seniors

Other (please specify)

17. What are some of the responsibilities of your role? (Choose as many as apply.)

☐ Preaching/teaching

☐ Counseling/spiritual guidance

☐ Event planning/coordination

☐ Coordinating volunteers

Other (please explain)

Follow Up Interview

Thank you for your time in completing this survey.

If you would be willing to participate in a brief (15-20 minute) follow up interview, please contact me at klittle@smith.edu or 503.329.5321 to schedule a time. Thank you so much!

Appendix D

Follow Up Interview Question Guide and Informed Consent Document

These are the questions that were asked by the researcher during the follow up interviews.

*Tell me about your beliefs about some of the causes of depression and other mental health problems in your congregants.

*What are your thoughts about the theory that mental health problems may be a result of chemical deficiencies in the brain?

*When you work with congregants who ask questions like "Why do I feel this way?" or "Why is this happening to me?" … what is your typical response?

*Tell me about your beliefs about substance abuse and addiction to things like pornography, internet, or gambling. How are these problems generated? How can your congregants manage such issues?

*If your congregant were to ask you for scripture(s) to read about either mental health or addiction issues, which would you refer them to?

*Have you had any specific training related to mental health or substance abuse issues? If so, where? Has such training been helpful to you? What might have been useful or not useful in such training?

* Is there anything I have not asked that you believe would be useful or important for me to know about your experiences or beliefs concerning these topics? Anything I have forgotten, or not stressed enough?

Informed Consent Form - Interview

Dear Participant:

As you know from your participation in my survey, my name is Katryn Little. I am a second year Master's degree student at Smith College School for Social Work. Just as a reminder, my study is aimed at illuminating the views about mental health problems and substance abuse issues that are held by designated adult leaders in Christian churches, and the research I gather in this study will be used as a part of my MSW thesis and in possible future professional or public presentations and publications.

I am grateful for the information you have already given in my survey, and would appreciate the opportunity to interview you in greater depth. I am especially interested in more detail about your experiences in working with people in your church who may have mental health problems or are dealing with their use of drugs or alcohol. The interview I hope to do with you will take between 15 to 20 minutes, depending on the level of detail you choose to offer, and will focus on your understanding of the causes of your congregants' mental health problems and drug and alcohol use. This interview may be face to face or over the phone or via the internet (in Skype, gchat, etc.) -- whatever is most convenient given your geographic location or personal preference. The interview would be audio recorded, and I will be transcribing the interview from the recording.

It is my hope that you will be able to benefit from this study through a discussion of various views of the causes of mental health and substance abuse issues. As with the survey you have completed, it is possible that through this process, you may recall a situation that you wish you had handled in a different manner, and may experience discomfort. If that should occur, I urge you to utilize the resources that you would recommend others use. I am not able to offer compensation for your participation in the study beyond thanks for your time and willingness to help supply information about improving the lives of those you lead.

If you choose to be a part of the follow-up interview process, I will ensure your contact and identifying information stays confidential through using numbers to identify each participant and changing identifying information in the interview transcriptions I develop before they are viewed by anyone else. My research advisor will have access to the data collected, but will not receive any identifying information about anyone who chooses to participate. All data collected through this study will be saved for a period of at least three years in a secure location as required by federal guidelines. Electronic data will be encrypted and stored and tapes and transcripts of interviews will be locked in a secure location. All information will be destroyed after three years, or if needed beyond three years, retained in its secure location.

Your participation in this study is completely voluntary. You may choose to withdraw from the study at any time during the interview and you may refuse to answer any specific question without withdrawing from the study as a whole. Once the interview is completed, if you wish to withdraw your information from that, please contact me no later than 48 hours after the completion of the interview. If you choose to withdraw from the study, all information relating to you will be destroyed immediately. If you have any concerns about your rights or about any aspect of the study, please contact me at klittle@smith.edu or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585 – 7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY. A copy of this form has been included for you to keep with your records. Thank you so much for your time and participation in this study.

_____   _____
Participant Signature   Date

_____   _____
Researcher Signature   Date