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*Seattle Pacific Seminary*

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Responses to a Sunday School Curriculum on Mental Illness in the Church

Megan M. Hamshar

Seattle Pacific University

Responses to a Sunday School Curriculum on Mental Illness in the Church

By Megan M. Hamshar

A thesis submitted in partial fulfillment

Of the requirements for the degree of

Master of Arts in Theology

Seattle Pacific University

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Approved by

*Marcia Webb PhD*

(Marcia Webb, Ph.D., Thesis Advisor,  
School of Psychology, Family, and Community)

Program Authorized to Offer Degree

School of Theology

Date

*June 4, 2014*

*Richard B. Steele, PhD*

(Richard B. Steele, Ph.D., Associate Dean, Seattle Pacific Seminary)

### **Abstract**

This thesis explores perceptions and attitudes toward mental illness in the church through a literature review of existing research in psychology, supported by a qualitative study of participants in a Sunday School series on mental illness. The four-week course was taught in a class of adults in their twenties and thirties in a Free Methodist church. The results from the study largely support the empirical literature that suggests the church holds primarily negative perceptions and attitudes toward mental illness and the persons it affects. However, the study also suggested that education may encourage self-analysis of negative attitudes and behaviors toward mental illness and change existing perceptions. In addition, the study showed that storytelling was the most impactful means of changing perceptions and alleviating the stigma surrounding mental illness. The literature review and the qualitative study were used to develop a preliminary theological approach to mental illness. Building on the framework of disability studies, this thesis discusses mental illness through exploring the concept of the stranger, the nature of humanness, and the body of Christ as an interdependent community that becomes a place of belonging for persons with mental illness.

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## CHAPTER I

### Introduction

Mental illness is a taboo, a subject that is not necessarily safe to discuss, not only in public but also in the church (Carlson, 1994; Corrigan, 2004; Dorrell, 2006; Redfield Jamison, 2006; Stanford, 2008). Underlying the silence around mental illness in the church are strongly held perceptions and attitudes about mental illness and the persons who experience it. Even if Christians do not have a good understanding of the topic, members of Protestant congregations still tend to hold negative attitudes about mental illness and the persons affected by it (Hartog & Gow, 2005; Rogers, Stanford, & Garland, 2012; Stanford, 2007; Stanford & McAlister, 2008). For persons with mental illness, to self-disclose a psychiatric diagnosis or experiences of mental illness may expose oneself to stigma and alienation one from one's faith community (Goffman, 1986, reissue; Stanford & McAlister, 2008).

The church is meant to be a place where the broken receive welcome, care, and love, a place where we recognize that all persons are in need of a savior, whether sick or well (Held Evans, 2011). However, the majority of literature that has explored the perceptions of persons in the church demonstrates that laypersons do not welcome or care for persons with mental illness or their families.

In fact, many persons are hurt in the process of sharing their burdens with the church (Hartog & Gow, 2005; Rogers et al., 2012; Stanford, 2007; Stanford & McAlister, 2008).

Most Protestant traditions officially state that mental illness is primarily a medical condition that may be helped by medication and therapy (Hartog & Gow, 2005). Generally, denominations do not deny the power of healing prayer for treatment, but they also acknowledge that mental illness is not solely a spiritual issue. However, this message does not seem to be reaching members of Protestant congregations. Many laypersons continue to believe that mental illness is primarily spiritual in nature (Hartog & Gow, 2005; Stanford, 2007; Stanford & McAlister, 2008; Trice & Bjork, 2006), and congregants tend to hold theologically conservative views of mental illness that promote repentance and healing prayer as the exclusive means to overcome personal struggle (Hartog & Gow, 2005).

Mental illness is not often discussed from the pulpit, though some prominent Christian leaders, including John MacArthur, Joel Osteen, and Joyce Meyer assert that that God's will is not synonymous with mental illness (Carlson, 2006; Webb, Stetz, & Hedden, 2008). According to various ministers, true Christians should be happy (Carlson, 2006; Osteen, 2004). In addition, some authors point to negative thinking and submission to demonic forces as the sources of continual suffering (Meyer, 1995; Osteen, 2004).

Others explicitly tell those who are experiencing any emotional pain to take the initiative, through willpower, to overcome negative emotions (Omartian, 2002). The impetus for healing remains with the sufferer.

Webb et al. (2008) also discovered that some Christian self-help texts label persons suffering from depression as in some way failing to abide by the true Christian faith. They do not have enough faith, or are in some way making a choice to remain ill (Osteen, 2004). Therefore, as a sign personal failure, sin, or demonic activity, mental illness is stigmatized, and persons with mental illness are labeled and rejected (Carlson, 2006). Even if these beliefs are not often openly taught from the pulpit, neither are they corrected.

The National Alliance on Mental Illness (2013) described mental illness as “a medical condition that disrupts a person’s thinking, feeling, mood, ability to relate to others and daily functioning” (p. 1). However, many parishioners do not know the definition or symptoms of mental illness, or that one in four adults in the United States has a diagnosable mental illness (National Alliance on Mental Illness [NAMI], 2013). Because mental illness is invisible in many ways, laypersons may not know the impact mental illness has upon the lives of many persons in their congregations and their families (Rogers et al., 2012; Stanford, 2007). Persons with mental illness may experience stigma, shame, and rejection when they exhibit odd behavior, neglect personal hygiene, or disrupt the flow of a worship service (Dorrell,

2006; Goffman, 1986, reissue). Persons with mental illness may leave the church or even renounce their faith because of the encounters they have in the church (Stanford, 2007; Stanford & McAlister, 2008).

An over-emphasis on spiritual attributions to mental illness has a negative impact upon persons with mental illness and their families, primarily through stigma and shame. Goffman (1986, reissue) described stigma as prefaced by reducing the humanity of a person to those attributes which society deems different. These characteristics allow persons who are considered to possess a “normal” social identity to discredit the stigmatized person as a failure. The attributes of the person who is stigmatized are considered “less desirable...bad, or dangerous, or weak” (p. 3). For persons with mental illness, stigma may appear in the form of attachment of stereotypical words conjured by the term, like “nuts,” “psycho,” “spastic,” and “crazy” (Rose, Thornicroft, Pinfold, & Kassam, 2007).

Stigma may also appear in attachments to certain images, such as dangerousness and criminal activity (Stout, Villegas, & Jennings, 2004), or through exhibiting strange behavior, including lack of personal hygiene or talking to oneself (Corrigan & Kleinlein, 2005). In the church context, mental illness may be also attached to images of demons (Hartog & Gow, 2005; Stanford, 2007; Trice & Bjork, 2006).

These words and images tend to build on one another and solidify a picture of mental illness that creates an atmosphere of fear and avoidance in the church.

Persons with mental illness are also negatively impacted when they experience judgment and rejection in the church. Clergy or laypersons may tell a person with mental illness that they do not have enough faith (Carlson, 1994; Stanford, 2008; Trice & Bjork, 2006) or that their illness is caused by personal sin (Carlson, 1994; Stanford, 2008), which creates shame. Brown (2012) said that, “shame is the intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love and belonging” (p. 69). Shame keeps people with mental illness silent in the church (Carlson, 1994; Townsend, 2006).

Research on mental illness primarily emerges from the field of psychology, including studies on mental illness in the church. However, the literature has not fully explored the roots of these negative attitudes, particularly from a religious standpoint. Works that come from religious traditions are primarily anecdotal, or written by Christian mental health practitioners with little theological training. A theological framework around mental illness may be important for understanding the underlying perceptions of persons in the church regarding mental illness.

Empirical research on perceptions of mental illness in the church from the religious academy is lacking, so a qualitative analysis of the lived experiences of persons in the church may be an important contribution to theological scholarship.

In addition, utilizing the lens of the Christian church's historical understanding of what we now term "mental illness" may help us to better understand the perceptions and treatment of individuals who are marginalized in today's church. Therefore, this thesis seeks to add to the body of literature from a theological perspective in the Protestant Christian tradition. In addition, a study using grounded theory will supplement the literature to explore the impact of a curriculum on current perceptions and attitudes of laypersons in Protestant congregations.

### **Review of the Literature**

This literature review will cover research on the particular attitudes and perceptions of mental illness held by laypersons in the church as well as the experiences of persons with mental illness and their families. In addition, while studies conducted on the connection between media exposure and perceptions of mental illness among persons in the church is lacking, research on mental illness and violence in the general public will be addressed. The anecdotal work of Christian leaders who have worked directly with persons who have experienced stigma, shame, and rejection in the church will be incorporated with the empirical research of those in the mental health profession. Existing curriculum for the church that specifically addresses mental illness will also be briefly covered.

### **Church Attitudes toward Mental Illness**

Persons in Protestant congregations tend to hold negative attitudes and perceptions of mental illness, citing explanations for these disorders from the results of sin (Stanford, 2007; Stanford & McAlister, 2008), to lack of faith (Carlson, 1994; Stanford, 2008, Trice & Bjork, 2006), to demonic activity (Hartog & Gow, 2005; Stanford, 2007; Stanford, 2008). Many laypersons attribute mental illness to spiritual causes, often rooted in personal failure. Protestant Christians may also diminish the role of the medical community as a source of treatment for mental illness and instead focus on healing prayer (Trice & Bjork, 2006).

**Mental illness as the result of personal sin.** Some Protestants emphasize personal sin as the root of mental illness (Stanford, 2007; Stanford & McAlister, 2008). While the literature demonstrates that personal sin is a factor in negative perceptions of mental illness, it does not explain why persons in the church may hold this attitude. This viewpoint might be explicated by the perspectives of Christian leaders who have seen firsthand the impact of this perspective on persons with mental illness. Carlson (1994) shared the story of one woman who attended a faith healing service, hoping for relief from her struggles with depression. Instead, as she reached the front of the line, she was told that she would not receive prayer because people who experienced depression only felt sorry for themselves, which is a sin. Stanford (2008) mentioned that Christians sometimes believe that people use

the term “mental illness” as a way to disregard or even validate willful personal sin. It is no wonder then, that a woman seeking healing might be told that depression is simply an excuse for an unrepentant heart.

**Mental illness as the result of lack of faith.** Lack of faith is another commonly espoused cause of mental illness in the literature (Carlson, 1994; Stanford, 2008, Trice & Bjork, 2006). Stanford (2008) shared the story of a woman who was told that she would not struggle with mental illness if she only believed and prayed enough. With sufficient faith, she was told she would be healed. However, she never experienced healing. Though Christians with mental illness may pray for healing as suggested by some prominent Christian leaders, healing does not always immediately occur (Gaiser, 2010). Because the church holds a strong correlative belief between faith and healing (Carlson, 1994; Stanford 2008), the lack of immediate healing may lead persons with mental illness to self-stigmatize (Corrigan, 2004). The woman in Stanford’s story left the church because she felt judged for not having enough faith. Since leaving the church, she now believes that members of the congregation doubted whether her illness was real.

**Mental illness as rooted in demonic activity.** Most Protestant denominations officially refute the demonic nature of mental illness and acknowledge the natural or psychological causes of mental illness (Hartog & Gow, 2005). However, members of theologically conservative churches, particularly



evangelical Protestant denominations, strongly believe in the roots of mental illness as located in demonic activity (Hartog & Gow, 2005; Stanford, 2007). Those who espouse these beliefs also tend to promote prayer as the most effective treatment for mental illness (McLatchie & Draguns, 1984; Trice & Bjork, 2006).

While a large number of churchgoers believe that demon possession and mental illness are intricately linked, the reasons behind these beliefs have not been investigated in the empirical literature. Stanford (2008) pointed out that while demon possession is only mentioned in five of the thirty-one healing stories of Jesus or his disciples, some Christians point toward these stories as evidence that mental illness is caused by demon possession. One reason behind such beliefs is the attachment of mental illness with certain behaviors. Some persons with mental illness might use unusual speech patterns, appear unkempt, or act erratically. Hallucinations or delusions may accompany such behaviors. One character that highlights this connection is the Gerasene demoniac in Mark 5, who self-harmed, possessed inhuman strength, screamed night and day, and wore no clothing. Thus, Stanford stated that it is understandable that some Christians may correlate the behaviors of persons with mental illness with demon possession (2008).

**Resistance to medical model of mental illness.** Among all Protestant denominations, persons in Pentecostal churches most commonly tend to disbelieve mental illness as a medical issue, although research indicates they have a good

understanding of psychology and the medical terminology of mental illness.

Pentecostal theology focuses on experiential spirituality, promoting happiness and peace as essential marks of a believer. Pentecostals tend to be theologically conservative, and members of these congregations encourage persons experiencing any psychological distress to pray for healing. Congregants consider faith in God as the primary means to alleviate any sort of suffering (Trice & Bjork, 2006).

In a time of psychological distress, most Christians first seek out a clergy member for assistance, and clergy often serve as the primary source of treatment (Stanford, 2007; Stanford & McAlister, 2008; Townsend, 2006). Because many Christians, especially Pentecostals, believe that mental illness is an exclusively spiritual issue, they tend to hold suspicious views of the mental health profession (Stanford, 2007). Some believe that because the medical profession is secular, medicine or therapy are ineffective, unnecessary, or even a crutch. They believe that only God can cure mental illness (Trice & Bjork, 2006). One author of Christian self-help texts also claims that reliance on medical treatments for depression and other mental illnesses, most commonly in the form of medication, actually makes suffering worse (DeMoss, 2001).

These beliefs are also rooted in the anti-psychiatry movement of the 1970s (Stanford, 2007). This movement came about as a reaction to the medical model of mental illness, which tended to focus on the causes of illness as outside a person's

control. The anti-psychiatry movement thus emphasized personal responsibility for overcoming or receiving healing for mental illness. The apparent “victimhood” mentality advocated by the medical community clashed with the church’s emphasis on free will and self-reliance. According to this viewpoint, human agency empowers individuals to control or overcome illness (Dain, 1989). This viewpoint continues to impact the church through popular Christian self-help texts that promote repentance, prayer, and positive thinking (Webb, Stetz, & Hedden, 2008).

Based on Trice and Bjork’s study (2006), it is possible that some Pentecostals may believe that lack of faith causes illness. At the same time, the research does not address this tendency among conservative congregations to acknowledge medical terminology for mental illness while simultaneously denying mental illness as a medical condition. Further research should investigate the tension between acceptance of medical terminology and attributions of spiritual causes for mental illness.

**Violence and unpredictability.** Gray (2001) surveyed a conservative Anglican congregation in the United Kingdom and found that negative spiritual attributions to mental illness were not prevalent in this congregation. However, she did find that congregants believed that persons with mental illness were violent and unpredictable. Similarly, McLatchie and Draguns (1984) also discovered that conservative Protestants were more likely to perceive persons with mental illness as

dangerous and lacking moral fortitude or control over their emotions. These findings may indicate that churchgoers are more influenced by media portrayals of mental illness than by spiritual attributions of mental illness and focus on behavior rather than causes, attitudes that fall in line with those of the general public. However, neither study addressed this possible connection between religious attributions regarding mental illness and media portrayals of the subject.

***Stigma and the media.*** According to Stout et al. (2004), persons with mental illness tend to be portrayed on television as more violent than persons in the general population. Though more research needs to be conducted, as of twenty years ago over half of all criminal perpetrators on primetime television, including dramas and news pieces, are portrayed as persons with a mental illness. This is also true of persons with mental illness featured in movies (Diefenbach, 1994). These images of violence conjure up negative terminology among viewers. A study conducted by Wahl and Roth (1982) found that among the most frequent terms used by participants to describe persons with mental illness featured on primetime programming, “aggressive,” “dangerous,” and “unpredictable” ranked highly. These connections between images and words solidify in the minds of the public that persons with mental illness are to be feared, which leads to stigma and rejection (Stout et al., 2004).

Stout et al. (2004) argued that mental illness is intimately connected with stigma as one of the most negatively branded conditions in the United States. According to Stout et al., stigma may be understood according to the activities of persons who stigmatize, including labeling and connection with unfavorable personal characteristics, which produces discrimination. This is most commonly witnessed in the media-fueled public connection between mental illness, violence, and unpredictability.

It may be likely that public perceptions of mental illness and violence also impacts perceptions of mental illness in the church (Gray, 2001), given that approximately 74% of persons in the United States consider themselves either somewhat or very religious (Baylor Religion Survey, Wave II, 2007), and nearly all homes in America have at least one television (Nielson, 2009). The combined impact of the media and spiritual attributions of mental illness create an atmosphere of stigma and shame for persons with mental illness in the church.

**Inconsistencies and contradictions in the literature.** There are some exceptions to the body of research on the pervasive nature of negative perceptions of and attitudes toward mental illness in the church. Though some persons with mental illness leave the church as a result of negative encounters, data from the study conducted by Stanford and McAlister (2008) disputes this claim.

They discovered that a significant number of persons with mental illness in charismatic churches attend church more than once a week. Even though members of the congregation tended to distrust medical diagnoses or the need for professional treatment, some persons with mental illness were drawn toward the church in order to pray more fervently for healing.

Persons seeking help from charismatic churches may internalize certain beliefs regarding mental illness, attributing their struggles to personal failure, which calls for repentance and prayer for healing. This may be an indication of self-stigma, an internalized acceptance of public stigma that leads persons to believe they are to blame for their illness (Corrigan, 2004). Trice and Bjork (2006) also found that persons in Pentecostal traditions are more likely to embrace emotional distress as part of their experiential-focused religious life and reported fewer symptoms of depression. However, the majority of participants in the studies conducted by Stanford (2007) and Stanford and McAlister (2008) reported decreased church affiliation as a result of interactions with the church, thus limiting these findings.

**Limitations of the literature.** Many studies were limited to primarily Caucasian and in some cases highly educated populations (Gray, 2001; Hartog & Gow, 2005; Trice & Bjork 2006). Some studies also interacted with a population in a single geographical area (Gray, 2001; Hartog & Gow; Trice & Bjork, 2006). In

addition, Stanford's (2007) study was limited by lack of knowledge of the denomination or theological beliefs of the participants. Negative interactions with the church were not rigorously assessed. Thus, he suggested that further research study the causes of negative interactions between persons with mental illness and members of the church.

Similarly, little research has been conducted directly upon the interactions between families and laypersons in the church, and the study conducted by Rogers et al. (2012) is limited by the lack of rigorous identification of family members of persons with mental illness. The question remains as to whether congregations know about families within their churches, or if they are addressing needs of these families. Finally, Rogers et al. did not address whether families of persons with mental illness are actively seeking the assistance of the church.

Sample size appeared to be a limiting factor in several studies. Hartog and Gow (2005) did not obtain a representative sample for their research study, and, according to the authors, should be considered exploratory. The study conducted by Stanford and McAlister (2008) was also limited by a small sample size, and they warned that their results should be viewed as preliminary. Stout et al. (2004) noted that their study provides only conditional evidence of the relationship between media images and stigma due to the sample size and the lack of experimental research.

Stanford (2007) used a non-random convenience sample of Internet users, which Stanford and McAlister (2008) also chose as their sample population. Hartog and Gow (2005) also noted that their sample base drew from volunteers, which could have impacted results due to participant interest in the study. Participants may have also responded to the questionnaire in ways they deemed appropriate for a Christian. The same limitation could have affected both Stanford and Stanford and McAlister's studies. In addition, Gray (2001) studied a single church in a neighborhood with a large population of persons with mental illness. Thus, exposure could have impacted results.

### **Impact on Persons with Mental Illness**

Negative attitudes and perceptions of mental illness among laypersons are pervasive and tend to increase alienation, isolation, shame, and stigma. Despite increased awareness and understanding of the medical nature of mental illness among church congregants over the past thirty years, a significant number of persons with mental illness report negative interactions with the church upon seeking assistance during a crisis (Stanford, 2007; Stanford & McAlister, 2008).

Those who approach the church seeking guidance, counseling, support, and understanding of their condition often leave discouraged when their pleas are ignored. When seeking help, experiences of disappointment and hurt increase the likelihood of shame and self-distancing (Stanford, 2007). While the church should be



a place where persons with mental illness receive compassion, support, love, and friendship, a significant number of persons with mental illness believe that family and friends outside of the church offer more support during times when they need to lean upon others (Stanford & McAlister, 2008). It may not come as a surprise, then, that some persons with mental illness want no further involvement from the church because interactions with congregants adversely impacted their lives (Stanford & McAlister). Some persons leave the Christian faith altogether because of negative interactions with the church (Stanford).

While some persons avoid the church, others keep quiet in their pews (Rogers et al., 2012; Stanford, 2007; Stanford & McAlister, 2008). They remain strangers because they have not received welcome and belonging in the body of Christ. The same impact can extend to the families of persons with mental illness.

### **Impact on Families of Persons with Mental Illness**

Rogers, Stanford, and Garland (2012) discovered that families caring for a loved one with mental illness deeply desired assistance and support from their faith community, specifically in the context of the Protestant tradition. Families caring for loved ones with mental illness experience higher stressors, including financial struggles, conflict, and crisis. Yet, the vast majority of families in this study received little to no support from the church. Their suffering was ignored. Despite the prevalence of mental illness in the church, laypersons by and large are not

aware of persons with mental illness or their families in their midst, according to Rogers et al. They do not bring casseroles. They do not send cards or flowers. They do not visit the families or offer to provide respite care (Rogers et al.).

According to Rogers et al. (2012), families may not be willing to share their burdens with the congregation because of commonly experienced stigma, as is the case for persons who are diagnosed with a mental illness. Families of persons with mental illness tend to be less involved in the life of the congregation, perhaps because of fears related to stigma. When mental illness is seen primarily as a spiritual issue, families may be more reluctant to share their needs in the church for fear of judgment and rejection.

Rogers et al. (2012) also asserted that families of persons with mental illness are not only impacted by the burden of perceived stigma from the church but also by internalized self-stigma. It is very common for persons caring for a family member with a mental illness to experience shame for holding conflicting feelings about their loved one, including thoughts that that the person is a burden, or that they wish they did not have to care for their family member.

### **Perspectives on Mental Illness from Christian Leaders**

In addition to empirical research, evidence about attitudes toward mental illness in the church can be seen in Christian texts and anecdotal accounts from Christian professionals. Among Christian literature, Dwight Carlson, a Christian

psychiatrist, and Jimmy Dorrell, a pastor of an outdoor congregation, offered compelling stories of persons with mental illness in the church. Carlson (1994) met with many patients who have been hurt by negative perceptions and interactions in the church. He shared their stories, along with reasons for the church to show compassion towards persons with mental illness, instead of offering judgment for those who are suffering. However, although he successfully answered “why” members of the church tend to hurt persons with mental illness, his text was not as thorough in his attempts to practically apply his reasoning, other than through a few Bible verses that point toward showing compassion for those who are suffering. At the same time, he did emphasize that clergy and congregational education on mental illness is essential in order for the church to move from a place of wounding to a place of compassion.

In a series of vignettes featuring members of his outdoor congregation, pastor Jimmy Dorrell (2006) shared his experiences working with persons who might be considered “trolls” in American society, according to the fairy tale of the Three Billy Goats Gruff featuring a troll under the bridge. These so-called “trolls” include persons with mental illness (p. 24). Overall, Dorrell showed compassion for persons with mental illness. However, he also tended to sentimentalize and promote persons with mental illness as superheroes to emphasize the humanity and gifts of persons with mental illness. Unfortunately, his use of hyperbolic language served to creates

a division between persons who might be called “normal” and those who might be called “trolls.” In his viewpoint, it appears that “trolls” have greater value and worth than others in the church.

### **Education and Instructional Resources on Mental Illness in the Church**

Protestant congregations have a great opportunity to care for persons with mental illness and their families, to offer not only presence but also friendship, which reduces isolation from community. However, the burden must be known. This involves risk, as it does for every person with a mental illness in the church who wishes to receive support. Researchers have recommended congregational education as a means to change perceptions of mental illness, alleviate stigma, and invite persons with mental illness to become a part of the church community (Gray, 2001; Rogers et al., 2012; Stanford & McAlister, 2008; Trice & Bjork, 2006).

Some educational resources are available to churches that promote awareness and focus on reducing stigma. FaithNet, a group of members and friends of The National Alliance on Mental Illness (NAMI) who feel called to assist in caring for those impacted by mental illness in the context of faith communities, offer a curriculum entitled, “Reaching Out to Faith Communities” (2011). This resource equips NAMI members to provide faith communities with accurate information regarding mental illness. Their material includes definitions, symptoms, potential causes, and stigma surrounding mental illness, as well as the opportunity for NAMI

members to share their own stories related to mental illness. The goal of this curriculum is to break the silence around mental illness and promote faith communities as places of welcome and belonging.

Like FaithNet, Rogers et al. (2012) also recommended sharing stories, which enables congregations to witness how the church can help, or should have helped in a particular situation. Again, this involves risk. Congregants who may not be aware of mental illness are connected with real persons through sharing stories. They are able to put a face to mental illness. Rogers et al. hoped that congregants might find connection in hearing the stories of others who have experienced hurt in the church. All persons suffer in some way, and with this connection, congregants may find purpose in helping others. By offering presence and friendship, persons with mental illness and their families could become reconnected with the body of Christ. They may no longer experience rejection, and because of the bond between their brothers and sisters in Christ, they may not choose to leave the church, as is all too common.

Faith and Hope Ministries offers a resource entitled “Mental Illness and Faith Community Outreach,” which seeks to enable those in ministry to alleviate stigma and exclusion in their faith communities. Though the educational material is primarily gathered from NAMI, the text provides a strong theological framework for this resource that emphasizes the sacredness of every human life.

Through education, ministers and laypersons can then create communities that unconditionally love persons with mental illness and their families.

One unique aspect of this resource is the suggestion to incorporate the topic of mental illness in the worship service, including litanies, intercessory prayer, and preaching. The document also includes daily prayers for persons with mental illness as well as ideas for specific actions that would make faith communities places of welcome. The ministry supports hospital visitation by both pastoral staff and laypersons during times of crisis. This resource also provides tools for engaging in social action in the political, legal, and health care systems, as well as collaboration with the mental health community.

### **Purpose of the Present Study**

However, even though educational resources are available to the church, it is unclear how these resources may be impacting the perceptions and attitudes of mental illness in local congregations or if they are commonly used. In addition, the empirical literature (Gray, 2001; Trice & Bjork, 2006; Stanford & McAlister, 2008; Rogers et al., 2012) has not investigated education as a means to impact perceptions and attitudes of mental illness in the church. Therefore, in order to explore education and its impact on the lives of persons in the church, I conducted a qualitative study with participants in a Sunday School series on mental illness within my local congregation.

## CHAPTER II

### Method

Lichtman (2010) defined qualitative research as “ a way of knowing in which a researcher gathers, organizes, and interprets information obtained from human beings using his or her eyes and ears as filters” (p. 5). This type of research is geared toward interviews or observations of humans outside the laboratory. It is a process of gathering data on the lived experiences of people in their natural environment. I chose to use a qualitative approach to this study on perceptions and attitudes toward mental illness in the church because I wanted to know the viewpoints and experiences of a select group of people through personal conversation. Qualitative research has no one approach. Some choose to conduct research through phenomenology, while others use ethnography, case studies, or mixed methods. I used grounded theory as my research approach because I desired to continue speaking with a variety of people in the Sunday School class until concepts emerging from the data was saturated (Lichtman, 2010).

### Grounded Theory

According to Glaser and Strauss (1967), grounded theory can be understood as “the process of generating theory” (p. 31), which can take many different forms. Grounded theory incorporates multiple sources of data. In this research, I included tape-recorded transcripts from each interview, as well as field notes I took

immediately following each interview. The generation of theory is “ever-developing” (p. 32). It changes as one continues to gather and review data. The constant-comparative process of grounded theory allowed me to return to the data multiple times, comparing the viewpoints of the interviewees, in order to hone in on themes and generate theory around those themes.

Using grounded theory, I analyzed interview transcripts to discern the perceptions of mental illness both within and outside the church, based on the experiences of participants who participated in the Sunday School series on mental illness. During this analysis, I reflected on both the participant’s comments and my own experiences during the interview. I also analyzed my role as the researcher and how I might have impacted the interview.

### **Selection of Participants**

To be eligible to participate in the research study, participants were required to have attended at least two sessions of the four-week series conducted in April 2013 entitled, “An Invitation to Community: Toward a Compassionate Theology of Mental Illness in the Church” at a Free Methodist church in Seattle, Washington. Because the interview questions were open ended and referred to general perceptions of mental illness before and after the series, the qualifications for participation were open to persons who did not attend the entire series.



The four-week series was designed and conducted by the principal investigator. It covered subjects including a medical definition of mental illness and symptoms of commonly diagnosed mental illnesses. I shared my own personal journey with mental illness, including my experiences of depression and suicidal ideation, struggles to find the right medication, eventual diagnosis of bipolar disorder, and my hospitalization following a manic episode. The series also broadly covered stigma, from the media, to the healthcare and justice systems, as well as in the church. Two healing stories in the gospels of Mark and one story in John were addressed and presented with interpretations that are not commonly taught in the church. The final week of the series examined the role of community in the lives of persons with mental illness, including how the community of the 20s/30s Sunday School class might become a place of welcome and belonging for persons who are typically marginalized.

### **Method of Recruitment**

This study involved a purposeful, convenience sample of individuals who are not representative of the congregation of the Free Methodist denomination or the worldwide church. However, grounded theory dictates that research is not intended to be representative or generalizable. Grounded theory explores the perceptions of a particular group of people. As the researcher, I was intimately involved in the research process, as I both taught the series and shared my own experience of

mental illness. Because those participating in the study know me outside of the church setting, I recognize that I played a significant role in the interviewer-interviewee interaction. I may have received interest in the study and willingness to participate because of my more personal, familiar quality with the subject as well as my relationships with the participants. In addition, there is something unique about a curriculum taught by a person whose life story includes mental illness. Therefore, participants may have had certain expectations of the study because of how they understood and related to my story.

Participants for the interviews were recruited through an email sent by a staff member at the Free Methodist church to members of the 20s/30s Sunday School group. The email is available in Appendix A. A reminder email was sent a week later to members of the group who had not responded. Participants were invited to contact the principal investigator if they met the criteria for participation and were willing to be interviewed. Because dual relationships were involved between the principal investigator and the potential participants, care was taken to avoid coercion. At the outset of each interview, I reminded the participant that their participation was voluntary, and that they were free not to participate without impacting our relationship. They were also free not to answer any particular question, or to end the interview, as they chose.

At the same time, the nature of the dual relationships may have positively impacted the study given the high response rate to the initial email invitation.

### **Interview Procedure**

Of the 29 original participants in the four-week series, 7 participants agreed to take part in the interviews. Interviewees included 3 females and 4 males (6 Caucasian and 1 Hispanic) ranging in age from mid-20s to mid-50s. One interview was not tape-recorded due to researcher error, so the data from that interview has been eliminated from the final data analysis. All interviews were conducted in a private university office at a time convenient for the participant. Interviews lasted between 35 minutes and 2.5 hours. Questions were semi-structured, and I encouraged participants to elaborate on their experiences before, during, and following the teaching series. As the interviewer, I followed a set of questions but also asked follow-up questions based on participant remarks that were not directly related to the set questions. This allowed me to gather additional data that might not otherwise have been considered. The interview guide is available in Appendix B.

### **Data Analysis**

Following the interviews, I used the methodology of grounded theory and transcribed each tape recording verbatim with the additional assistance of a transcriptionist. I printed each transcript, reviewed field notes, and conducted first cycle coding on paper, in which I looked for repeated terms and themes within each

interview as well as commonalities and differences across interviews (Saldana, 2008). I used the language of each interviewee to further develop these themes, called axial coding. Particularities of single interviews were not used in the discussion of the data.

I also discussed the interviews with my mentor in order to hone in on themes from the transcripts and field notes. Through these discussions and analysis, I reconfigured some initial themes in order to develop thick categories that revealed the common experiences of persons who participated in the Sunday School series. This last step of the constant-comparative process, called selective coding, completed the generation of theory.

As a person with mental illness, I have a particular bias toward perceptions of mental illness in the church. My own story involves rejection and judgment by particular members of the church, as well as silence around the subject in the church and in my family. The interview process included significant self-reflection on my part, as I recognized my biases rooted in my own story. I also recognized a tendency toward asking leading questions based on these biases, which I attempted to correct as I conducted further interviews.

## CHAPTER III

### Results

#### General Comments

Because the interviews were conducted nearly a year following the teaching series, it was interesting to discover what portions of the series were remembered. Initial emerging themes from the interviews revealed that part of the interview procedure itself allowed participants to process their thoughts regarding mental illness and the teaching series. For two participants, it was only during the interview and not earlier during the program itself that stories emerged regarding mental illness either in their family or friends. These stories became emotional, cathartic portions of the interviews. For another interviewee, re-living the experience of walking alongside me during several past emotional crises that I talked about in the series was deeply emotional. I offered each interviewee the opportunity to take a break or stop the interview during these times, but no participant chose this option.

Of the thirteen questions, only one question elicited very little data. In response to whether anything about the series was hurtful, most interviewees responded with short and non-elaborative answers, indicating they did not experience any hurt. Some program attendees reported experiencing discomfort, in

the sense that the topic elicited emotional experiences. Another interviewee mentioned experiencing shame regarding past behaviors.

This may be an indication that participants interpreted the term “hurtful” differently, perhaps as harmful, uncomfortable, or guilt inducing. Research confirms that guilt actually increases positive motivation, while shame is destructive (Tangney, Miller, Flicker, & Barlow, 1996). The interviewee who reported feeling “ashamed,” later told me that he felt called to pursue relationships with persons with mental illness, which is indicative of a positive response to the series content. Future research may study participant understanding and interpretation of that term.

Finally, this study did not focus on nonverbal participant communication other than in more salient cases, such as strong displays of emotion. Thus, participant quotations that appear in the following sections do not include any instances of repetitious stutters, or utterances such as “um” and “ah,” as these are considered common to human speech and not as relevant to the thematic content of the data.

### **Interview Themes**

The common themes that emerged from the study following data analysis revealed a strong connection with story and community as a means to humanize mental illness, to bring it out of the shadows, to alleviate stigma and shame the

exists around this subject matter and that impacts persons with mental illness on a day to day basis. Each of the following themes has been developed from the words of the interviewees themselves.

**Storytelling.** The importance of personal storytelling was a common theme, particularly the perceived risk and bravery that interviewees in the teaching series felt towards my willingness to be vulnerable with the group. During the first week of the series, I closed the session by sharing some of my story in relation to mental illness. I discussed my experiences and struggles with severe depression and suicidal ideation, self-harm, and homicidal behavior as a teenager and young adult. I also shared the challenges of finding a medication that would ease my symptoms and the severe side effects these medications sometimes incurred. I explained my eventual diagnosis of bipolar disorder as well as my struggles and movement toward recovery since my diagnosis.

Prior to this series, I never felt comfortable telling anyone about my experiences. I knew it was a taboo subject. I rarely discussed it with my parents. I never mentioned it to my extended family. I never discussed it with anyone in church. To share my story during this teaching series was both challenging and cathartic. I did not feel brave, but I also did not feel afraid. I knew that my story had to be shared in order for the taboo around this subject to be broken.

Without storytelling, this teaching series would just be another intellectual exercise. It would not be personal.

In response to this portion of the series, one participant mentioned, Your story cut through a façade for the group that is very typical for any social setting....It's unusual, in my experience, for groups to go to a level deeper, to have somebody genuinely say, 'I'm not okay,' or 'I've been through a road that has not been okay in the way society frames it.' That level of vulnerability felt very precious, and as I would say, holy, but groundbreaking, because it's like cracking through, again, sort of this façade.

Storytelling is not often mentioned in the literature, though some existing curricula do encourage leaders to share their own experiences of mental illness (FaithNet, 2011; Kehoe, 2009; Pathways to Promise, 2009). From the data collected from this set of interviews, it appears that storytelling was the most impactful and memorable teaching element.

In addition, two participants also mentioned that it might be important to hear the stories of other persons from different perspectives in a possible follow-up series. There are many different experiences of mental illness, not only from a person who has a diagnosable illness, but also families of persons with mental illness, mental health professionals, and pastoral counselors.



**Lack of understanding of mental illness prior to the series.** Most participants readily admitted to lack of knowledge of mental illness prior to the teaching series. One interviewee mentioned knowing a few friends with a mental illness but having no knowledge of mental illness itself. Another program attendee entered the series feeling very confident in her knowledge, but during the series, she realized that she had been “cavalier” about mental illness and was not prepared for the enormity of the issue or of the stigma that mental illness carries. Another participant also came into the series with personal knowledge of mental illness through her knowledge of my own struggle with mental illness. However, her feelings about other persons with mental illness tended to be more negative. As she said,

I felt like they were somehow volatile, or I might set them off or I might not understand their reaction and know how to handle it. I certainly did not intentionally put myself in situations where I was interacting with those individuals.

One participant claimed that his perceptions of mental illness did not change over the course of the series, though he recognized that mental illness is not commonly spoken of in the church. It is a topic to be avoided, or if mental illness is addressed, it is viewed as a problem to be fixed.

This participant noted that in his family,

People being in pain is painful for us, and the main way to stop that is to fix it. We want it out of the way because it hurts us too much to see it, and it's hard to live with pain around us.

Another participant also indicated that the church tends to avoid speaking about mental illness. "If we don't talk about it, then we don't really have to deal with it or have a position on it." At the same time, both of these interviewees noted that, unlike the larger congregation, this church's 20s/30s group is particularly open to addressing issues like mental health.

**Lack of contact.** Not knowing people with mental illness prior to the teaching series came up frequently in the interviews. However, although persons often made this statement during the first portion of the interview, some interviewees later revealed stories of persons that they either know or had known with a mental illness. This appeared to be part of the nature of the interview as an opportunity for processing and possibly uncovering otherwise unexamined portions of their history. Most participants noted they did not know anyone with mental illness in high school or college, though they sometimes referred to avoiding, fearing, or making fun of persons who they considered not "normal."

One participant, after stating that he did not have much experience with persons with mental illness, realized that,

Looking back at people I knew in middle school and high school, those are the kids that I made fun of because [sic] or distanced myself from because I didn't feel like they fit in with, you know, what I thought was normal.

**Self-analysis of negative viewpoints.** Several participants admitted to holding negative viewpoints of persons with mental illness. They also recognized how they treated persons with mental illness prior to the series, mostly in negative and harmful ways. The interviewees notably mentioned that most of their interactions happened during high school. Two participants purposefully distanced themselves from persons with mental illness in junior high and high school because of their attitudes. While one interviewee noted that his behavior was rooted in fear and lack of understanding, the other participant noted that he had been taught in his family that persons with mental illness essentially lacked the work ethic to overcome their deficiency.

Another interviewee noted that, "I think my perception of mental illness had been fairly narrow. That it's either this huge, big, bad, terrible thing for people out there, or it's like you have a little mild depression." During the course of our conversation, this participant stopped in the middle of answering another question as she became aware of a portion of her family history that she had not thought

about before or after the series. I noted a change in her emotional state as she shared the story of her “two crazy uncles,” which helped her to process her attitude toward persons with mental illness. She shared, “I think the reason I was putting people into categories is that I didn’t want to associate myself, even from my own family, with these crazy uncles. So, I’m just realizing I think that was self-protective.”

Another participant was struck by his potentially hurtful beliefs and behavior toward persons with mental illness when the class analyzed Scripture and how particular interpretations have been used to place the blame of illness upon the sufferer. He shared that, “I might have held some of those perspectives, you know, and to see how you described them as perpetrating harm, it made me feel, it made me question, had I perpetrated harm?” This question also led him to analyze how he might work toward becoming more aware of the suffering of persons with mental illness and purposefully seeking out relationships with persons with mental illness.

**Impact of the media on perceptions and attitudes toward mental illness.** Several participants mentioned the negative impact that the media has upon common perceptions and attitudes toward mental illness, both in the church and in public.

One interviewee noted,

I feel like the media in general portrays people with mental illness in extreme ways, particularly violent ways, but also in ways that make it seem like if you have a mental illness you can't function in society. You need to be a social outcast, or locked up in an institution.

Another interviewee connected the portion of the series that focused on stigma with media portrayals of persons with mental illness. She stated,

The discussion of stigma stood out to me, thinking about how mental health and mental illness is viewed in, particularly in the media...So, for example, any one of these unfortunate shootings at a high school, at a movie theatre, pretty much the first thing the media tries to identify is what their mental health background was.

This participant noted that media portrayals of mental illness in connection with violent acts tend to try to make sense of why a person would commit a crime.

However, she also worried that rationalizing a crime via a diagnosis of mental illness “instills in society, in the population in general, that that could be causation.”

**Impact of language.** Two participants were particularly mindful of the impact that language has upon perceptions and attitudes toward mental illness. I noted that one interviewee took great pains during the interview itself to avoid

using negative terminology, pausing frequently to find the right word. As a person with mental illness, my presence may have impacted this particular portion of the interview. By pausing before answering some questions, the participant may have actively sought to avoid offending me as a person with a mental illness.

The portion of the series that focused on language made a particular impression on another participant, especially in relation to the term “crazy.” This participant has taken active steps to eliminate negative terminology regarding mental illness from his vocabulary, such as “crazy” or “insane” but he also noted that these terms are “such [a] part of our slang culture of millennials, so I just feel like it’s so hard not to use those terms.” This participant also suggested that the language we use regarding mental illness is especially impactful on children. “Children learn from us through imitation, and if maybe we stop using terms that could be harmful, then kids won’t ever learn them.”

**Personhood.** Personhood emerged as another theme from the data. An important outcome of the series for one participant was seeing mental illness as a part, not the whole, identity of a person with mental illness. Another interviewee realized that devaluing personhood creates an “us” and “them” mentality, or “normal” people versus persons who are broken, who are not whole, who may not be fully human. One participant mentioned that, “wholeness doesn’t necessarily look like the certain level of cognition or ability that we expect but rather what that

person, in their personhood, brings to the community.” Some participants talked about the focus on person-first language throughout the series. Using terms like “the mentally ill” or “schizophrenic” as nouns indicative of individuals emphasize the illness over the person. However, learning and embracing language that acknowledges a person with mental illness as a person was impactful for some attendees.

**Community.** For one interviewee, this change of phrasing led him toward a new understanding of the body of Christ. “I kinda think it helped me see more about, like the body of Christ as a whole organism that we’re all a part of that when those that suffer are not cared for, then the entire body suffers.” Similarly, one participant connected personhood with Jesus’ call to love each other, which extends to every single person. “We are called to love a person. We’re not called to love people only if they meet specific criteria.” This statement elicited a tearful emotional reaction for this participant, as she recognized that my story was a humanizing agent toward recognizing personhood of everyone.

Another interviewee mentioned that following the teaching series, he connected the content I presented with John Swinton’s ideas about community and belonging. For this participant, the healthy community is a place where people can be vulnerable, where they will be welcomed even if they are not well.

He later shared that, “when we are vulnerable, that’s when we, that’s when Christ is strong though us, and as a community that’s how we’re healed and made whole.”

I also noted that many of his statements regarding community alluded to I Corinthians 12 and its description of the community of believers as a body. The teaching series, as it related to the work of John Swinton, led him to a new understanding of what it means to be the body of Christ. “As a body, we help each other with those things...and as much as those who are strong can help those who are weak, those who are weak can help those who are strong.” He later connected this scriptural mandate with his own calling. This attendee indicated that he would like to be able to develop healthy relationships that allow persons with mental illness to be themselves. At the same time, he intended to focus on awareness of how his actions may affect relationships, whether harmful or helpful.

**Attitudes of the larger church.** As mentioned earlier, the 20s/30s group came up in some interviews as somewhat of an anomaly among the Sunday School groups. According to program attendees, this particular class tends to be more open, accepting, and interested in learning more about topics that are typically avoided in the larger church congregation. While speculative, some participants offered opinions on what the larger church might believe about mental illness.



One interviewee shared,

I do think there is a portion of the Christian populace and I hope this is a very small portion, but sadly, I'm worried it's larger than I think, that believes that mental illness I caused by either an unfaithful [sic] or something as extreme as demon possession.

This same participant noted that she believes these beliefs regarding demon possession are more commonly found in fundamentalist or conservative churches. Another added that he believes shame-based attitudes toward mental illness are more commonly found in seeker-sensitive or mega-churches.

Another interviewee added that, "I think there's some kind of perspective that if I'm a Christian, I can't have any problems, especially mental illness." He connected this view of the victorious Christian life with the shame some persons experience in seeking medical treatment for what is considered a spiritual issue. Persons who are struggling with mental illness should be able to overcome through the power of the Spirit. He also mentioned shame in relation to a power differential in the church between persons who are supposedly weak and those who are strong. It "becomes the norm that those who display any sense of weakness with mental struggles, then that, you should be shamed for that, because you should struggle with that."

**Suggestions for the future.** One participant noted that in the community setting of the teaching series, she was “very aware that this was kind of groundbreaking...We just went somewhere in this setting that a lot of groups never do, and there was a holiness about that.” To be able to return to that sense of community was important for several participants. Two interviewees noted that, following the conclusion of the series, the growing sense of community that had developed over the course of the series had been lost. They believed it would be important to follow up on the series, in order to strengthen the community. These interviewees hoped that the Sunday School class would return to a safe place that allows persons to be vulnerable and share stories that may not be “pretty.”

Another suggestion related to a future teaching series involved more small group discussion time following an opening lecture each week. One interviewee suggested a pre-series survey for potential students in another teaching series. The survey would ask specific questions that would guide the focus of the content to address topics or questions of particular interest to students in the class.

Although many participants mentioned that small group development would be an important component of a teaching series involving a sensitive topic like mental illness, two interviewees noted that small groups must involve trust between members. Based on previous experience, one participant was particularly concerned about small groups as gatherings where one might share something

vulnerable and be told, “we’ll pray about that.” However, he feared that no real connection would be formed, and no relationship development would occur. Many interviewees had questions as to how the 20s/30s community, in smaller groups, might become safe places where more people can be honest and vulnerable with each other.

As mentioned previously, two interviewees also suggested that another series should incorporate the stories of other persons into the teaching. They believe that hearing different experiences and perspectives on mental illness would be helpful to understand the experience of mental illness more broadly. One attendee suggested a panel discussion for the wider church. Another recommended that persons within the 20s/30s group who might feel comfortable sharing their story would also be beneficial for the class.

## CHAPTER IV

### Discussion

#### Interview Themes in Relation to Empirical Research

Data from this research supports findings from previous studies. Several researchers have offered strong criticism of the church in relation to their perceptions of mental illness (Carlson, 1994; Dorrell, 2006; Hartog & Gow, 2005; Rogers et al., 2012; Stanford, 2007; Trice & Bjork, 2006). Persons with mental illness are frequently outsiders in the body of Christ. When they enter the house of God, they frequently receive condemnation from God's people. Attitudes toward mental illness within the church reveal an understanding of the Christian faith that does not recognize or accept persons who fall outside what is considered "normal," including persons who may not look or speak or behave like most members of a church congregation. The felt perceptions of the larger church shared by interview participants confirmed the literature pointing toward negative and exclusive attitudes.

As might be predicted from the empirical literature, some interviewees commented that they lacked personal understanding of mental illness and of persons with mental illness prior to the teaching series (Carlson, 1994; Stanford, 2008; Townsend, 2006). Participants admitted that they excluded or avoided persons with mental illness because they did not seem "normal." Interviewees also

confirmed that they felt uncomfortable around persons with mental illness prior to, and sometimes even after, the teaching series, whether due to media influence or discomfort with unusual behavior. They held unfavorable views of mental illness and may have associated mental illness with personal failure or with violence (Stout et al., 2004; Trice & Bjork, 2006).

Interviewees frequently made mention of the impact of the media on both their own perceptions of mental illness as well as their felt perceptions of persons in the wider church. One participant mentioned that the show “Dexter” was most influential in his understanding of psychosis and the terminology around mental illness. These statements are consistent with the literature on the relationship between media portrayals of mental illness and public perceptions of persons with mental illness (Diefenbach, 1994; Stout et al., 2004).

Based on the research conducted by Rose et al. (2007) on the language used by teenagers regarding mental illness, the participant who spoke of the impact of language on children raised a pertinent question regarding the origin of the terms that children and teens use around mental illness. This question also revealed a possible means to alleviate negative and harmful language, which should encourage further research. Participants who made painstaking efforts during the interview to avoid using negative terminology associated with mental illness demonstrated that

an educational resource such as a teaching series might be impactful on changing the way we think about the language we use when speaking about mental illness.

In addition, interviewees who offered suggestions for the future noted that a follow-up series could involve the perspectives of a variety of persons in order to grasp a fuller picture of mental illness. Participants mentioned that a follow-up series might include another teaching session geared toward the entire church. Other interviewees indicated a follow-up might involve a panel discussion that includes people from outside the church, those who work directly with persons with mental illness, as well as pastoral staff and other persons with mental illness. The body of literature supports these suggestions as researchers frequently suggest collaboration between churches and the mental health profession (Rogers et al., 2012; Stanford, 2007; Stanford & McAlister, 2008; Trice & Bjork, 2006), which supports the statements made by interview participants.

However, the empirical literature did not investigate several themes that emerged from the interviews. Though many participants claimed that they had little contact with persons with mental illness prior to the teaching series, some participants conducted self-analysis of their past treatment of persons with mental illness. During the teaching series, they realized the harm they may have committed. Interviewee reports of changing perceptions over the course of the series confirm the research that indicates exposure minimizes stigma (Corrigan & Penn,

1999). These participants looked back to high school experiences in which they treated persons who were not “normal” with disdain. Self-analysis of negative attitudes and perceptions gives insight into the impact of participating in a teaching series on mental illness, perhaps because it involved personal stories of experiences with mental illness.

Storytelling, which was the most common and impactful theme that emerged from the interviews, was also not addressed in the literature, with the exception of Rogers et al. (2012). Hearing each other’s stories may help to alleviate the stigma surrounding mental illness, and storytelling is also an essential component of what it means to be the church. We listen to the story of God, God’s people, and the life, death, and resurrection of Jesus as told in Scripture. We listen to the story of the church that continues the overarching narrative of God’s world. We listen, and then we act. Hearing the stories of others in the church, especially the stories of persons who are outcasts, helps the church to learn how to be the church, how to live out God’s call to “bring good news to the oppressed, to bind up the brokenhearted, to proclaim liberty to the captives, and release to the prisoners; to proclaim the year of the LORD’s favor” (Isaiah 61:1-2a, NRSV).

### **Theological and Biblical Analysis**

Based on the suggestions from interviewees as well as the literature review, moving toward a theology of mental illness should include a robust understanding

of Scripture, God's character, and what it means to be human, the *imago dei*. To be human, as Vanier (1998) claimed, is to see and be seen; to accept and be accepted; to love and be loved. We are invited to a table of belonging, a table where we develop friendships of mutuality, a place where we can fully be ourselves.

A theology of mental illness should also involve the importance of storytelling, which is demonstrated in the many parables Jesus told. Storytelling helps us to learn about God and about each other. Storytelling impacts our hearts and our minds. It should move us to action. As in the parable of the Good Samaritan, we should recognize that we are called to be people who care for those on the outside, those who are outcasts, rejected, strangers.

The work of Young (2007) focused on the stranger, the exile, and the sojourner. She noted that the church is called to welcome the stranger in our midst, who include persons with mental illness. Some churches do this well (Dorrell, 2006). However, the stories of persons with mental illness, shared with pastors or those in the mental health field reveal that it is much more common to experience judgment and exclusion (Carlson, 1994; Stanford, 2008; Townsend, 2006).

Too often, the stranger remains a stranger, an outcast. If people keep silent due to fear of judgment and rejection, then the church has failed to live up to its calling. The church has an opportunity to welcome the stranger, the person who is



not yet a member of the body, who needs a community that will suffer alongside them in crisis and celebrate with them in health.

As I Corinthians 12 proclaims, Christ calls the church to be a community that supports each other, who suffers with those who suffer. If members of the church fail to come alongside persons with mental illness and walk with them through experiences of suffering, then the church is not living up to its calling. If members of the community induce shame in a member of the body, then we commit great harm. The church may be a place where shame around mental illness is common, but as Brown (2012) claimed, “[i]f we speak shame, it begins to wither...language and story bring light to shame and destroy it” (p. 58).

**Mental illness in Scripture.** As Stanford (2007) briefly mentioned, scriptural references to stories of Jesus healing the sick often impact the perceptions and attitudes toward mental illness in the church. Many stories have been used to prove that persons with mental illness are demon possessed, are ill as the result of continued willful sin, or simply lack the faith to accept Jesus’ offer of healing. In the church, interpretation of selected scriptural passages has historically been used to support the exclusion and damnation persons with mental illness (Foucault, 2006).

However, there are many stories throughout Scripture that highlight the grace and compassion of God in regard to suffering, illness, sin, and healing.

Brueggemann (1985) presented a robust interpretation of Psalm 88, a bleak picture of suffering and darkness. As Brueggemann claimed, Psalm 88 offers a peek into the mind of a person who is suffering and is not afraid to be open about it. The author blames God for the situation, and demands an answer regarding the meaning of this suffering. It is notable among the psalms of lament, as it does not end on a hopeful note. Unlike the formula of many other psalms, God does not answer the plea of the sufferer. Instead, in the English Standard Version (ESV) translation, the psalm ends with “darkness is my only companion.” Unlike the biblical platitudes that are offered to persons with mental illness as words of encouragement, this psalm embraces suffering as reality. It does not mandate letting go of anxiety. It does not ignore pain or try to pray it away.

According to Gaiser (2010), three particular healing stories in the gospels offer a different picture of illness and healing in Scripture. The combined story of the healing of Jairus’ daughter and the healing of the woman with hemorrhaging in Mark 5, as well as the healing of the blind man in John 9 highlight the mission of Jesus: to heal, make well, and to restore people to community. Gaiser claimed that the two stories in Mark 5 turn expectations of healing upside down. Jairus asks Jesus to make his daughter physically well, but he used the Greek term *sozo*, meaning to “save, rescue, and liberate,” as well as to “heal and preserve.” Jairus’

usage of this term indicates that he seeks salvation for his daughter, which nods toward Jesus' own ministry on this earth.

The woman with hemorrhaging also asks to be made well, though unspoken. However, Jesus does not immediately make her well. Jesus immediately heals her without a word, but he does not save her – make her well. The impetus for the woman's salvation comes through conversation with Jesus. He makes her well and then saves her as he comes into relationship with her. According to the Law, this woman is ritually unclean, and therefore most likely an outcast. She lives outside the community. However, when Jesus makes her “well,” this action brings about physical, social, and religious healing. The walls that once kept her outside are broken, and she is both incorporated both into human community and the community of God's kingdom. This is both healing and salvation, as she enters into the community of the kingdom of God.

Jairus longs for his daughter to be made “well” and “live.” Like Jairus, we might expect that through this request, the girl will not die. However, Jesus spends time with the woman with hemorrhaging instead of hurrying to the girl's side, and news arrives that the girl is dead. Readers may wonder if his tarrying led to the girl's death, but Jesus tells Jairus not to fear. When he arrived at the home, Jesus commanded the girl to “get up,” and she immediately did so. The Greek term *koum*,

meaning “get up” or “arise” is frequently used in the New Testament to refer to Jesus’ resurrection. This story is a foretaste of ultimate healing, from death to life.

These two stories show that healing is not always an instantaneous experience. It is not a magic trick. Healing does not only involve touch, such as laying on of hands. As Gaiser (2010) said, “Wellness’ or ‘being saved’ comes only in the personal encounter with Jesus that involves words, communication, and promise” (p. 168). Healing is not only physical, as in the stories from Mark.

Gaiser (2010) also introduced a twofold understanding of healing in his interpretation of John 9. His view of the text highlights how the healing of the blind man brings not only physical sight, but also spiritual sight. This healing story has as much to say about Jesus as the light of the world as it has to say about physical wholeness. In John 9 the man born blind presents readers with a question persons in the church frequently ask regarding mental illness. Who sinned here? The assumption is that suffering or illness is the result of sin, whether personal or even generational, which alludes to Exodus 34. God is a God of justice.

However, as Gaiser (2010) mentioned, Jesus does not strictly abide by this one to one equation. While he does not deny that actions have consequences, Jesus lets it be known that we cannot always make assumptions about cause and effect, such as the connection between sin and suffering.

Only God holds this knowledge. Ultimately, God has revealed to human beings that Jesus identified with those who were suffering.

**Healing and salvation.** These stories from the Gospels of Mark and John illustrate that healing, faith, and salvation are related (Gaiser, 2010). However, they are not always related in the same way. For the woman with hemorrhaging in Mark 5, her faith made her well. For the blind man, his faith came as a result of healing. Healing is somehow related to faith, and both faith and healing are somehow related to salvation. However, the three are not connected in the way that the church commonly understands. Jesus used the stuff of earth, the stuff of his particular time in order to bring about healing. The writers of the gospels do not comment on any particular method of healing. It does not seem to matter *how* persons are healed. The focus is on the healer. Gaiser thus claimed that God's acceptance of the healing methods common in Jesus' day is not a permanent prescription for how to address sickness. Rather, Jesus' use of common first century healing methods should provoke awareness that God can also use today's medical practices to bring about healing. Gaiser again reminded readers that these stories hone in on the essence of healing. It is not the *how* but the *who*, the one who brings light and life to the world.

Gaiser (2010) has explained that one of the primary meanings of the Greek term *sozo* is to save one suffering from disease, to make well, heal, or restore to

health. Salvation means healing and healing means salvation. Salvation and healing are a life-long process, and may not be fully realized in this lifetime. However, perhaps what the church needs more than different interpretations or understandings of Scripture is to reclaim what it means to be human, and what it means to be in community. One of the best places we can learn more about humanity and community is through encounters with persons with disabilities, persons who will never walk, talk, see, or function at the typical intellectual level of an adult.

**Connections with disability studies.** While disability studies has produced a great deal of work on what it means to be made in the image of God and what it means to be human, theological approaches to disability have not directly addressed mental illness. However, some relevant themes can be extrapolated from disability studies to understand mental illness theologically.

In particular, the work of Hans Reinders and Jan Vanier, who have lived and worked with persons with cognitive and physical disabilities, described what it means to be marginalized and how Christians might learn to see every single person as wholly human and wholly valuable regardless of ability. Their approach to the nature of humanness when confronted with disability is particularly useful for developing an understanding of mental illness in a theological framework.

Based on his meeting and connection with Kelly, a young girl born without a significant portion of her brain and unable to move or speak, Reinders (2008) considered what it means to be human, especially when confronted by persons with profound disabilities. He suggested that Christians should interpret what it means to be human in a theological framework that appreciates each person as unconditionally human. In the same manner, the humanity of persons with mental illness does not need to be defended.

Instead of explaining what it means for persons with mental illness to be human, Christians must address what it means for each one of us to be human in light of the *imago dei*. All persons are all created in God's love. The significance of existence is dependent on something outside of the human being. By *interpreting* existence instead of *categorizing* existence, the church may see that humanity is rooted in the love of God. When viewed through the lens of God's love, the church as a place of welcome and belonging can invite persons with mental illness into meaningful relationships, which goes beyond mere inclusion.

According to Reinders (2008), the myth within American culture assumes the meaning of human life is made, not found, through the preservation of eternal youth, beauty, and mental and physical ability. Persons act in order to become more human. Vanier (2008) also noted that society's focus on beauty, intelligence, and success effectively informs individuals that they are not okay as they are.

The media perpetuates this myth through images that portray health and beauty as the essential features of a meaningful life. Persons with severe mental illness will never fit into these cultural ideals, which also represent the nature of humanness. If persons with mental illness are presented in the media, they are most often caricatures (e.g., either violent criminals or locked up in an institution).

It may come as a surprise, then, when a person falls outside the norm. Illness, pain, and suffering are often unexpected. These do not fit into the mythical American life. According to Reinders (2008), many people try to avoid any kind of personal suffering and blatantly ignore the suffering of others, especially persons with mental illness, who fall outside the norm. A society that avoids thinking or talking about suffering creates division and fear. Rampant denial of suffering prevents friendship with persons who are marginalized as a means to avoid personal suffering.

Vanier (2008) has reminded Christians that Jesus calls the church to love each other as he loved those who were most despised. As a human being who embraced outcasts, lepers, prostitutes and tax collectors, Jesus sought to break down walls of division in order to display his deep love for people just as they are. If the church cannot also accept and love others who fall outside the norm, then the church effectively establishes the means to marginalize the other, the stranger, and the outcast. Even with the best intentions, if acceptance and love requires a person



with a mental illness to change in order to prevent anyone in the church from experiencing discomfort, then walls of difference and fear will continue to exist.

Vanier (2008) further noted that Jesus desires to bring people to the table, to share life together. He says to each member of the body, “You are important. You are precious” (p. 63). In the L’Arche community, which Vanier founded in 1964, persons with disabilities and assistants are brought to the table to live, work, and play together. The assistant is not in charge. The person with a disability is not a patient. Both people enter into a relationship that leads them toward becoming more human. Both the assistants and persons with disabilities learn to see each other as sacred, in all their brokenness and weakness. Each person in L’Arche is important. Each person is precious.

As in the L’Arche community, all walls that separate persons will only be broken when each individual sees the other as important and precious. While many people, including those in the church, build walls out of fear and hatred, God wants to tear these down. Jesus’ mission is to raise up those who have been put down, bring good news to the poor, free captives and slaves, proclaim liberty to the oppressed, and reveal the way of embracing the outsider in love and compassion.

Reinders (2008) has argued not only for acceptance and love but also friendship. A Christian description of true friendship requires love and dedication to those who are despised and marginalized, and embracing those who suffer.

Reinders added that receiving the gift of friendship is the essential function of the Christian life, particularly from persons declared deficient. This argument can also extend to persons who are unlikable, strange, or have a mental illness. God's work of transformation in welcoming the stranger tangibly impacts the church when friendships of presence are developed. According to Vanier (2008), Christians who learn to love a person for the mere fact that they are alive, in the same way that Jesus declares the worth of every human being, also learn to enjoy being in the presence of others.

Vanier's (2008) understanding of what he considers the essential mystery of disability is rooted in weakness. Those who are terrified to reveal weakness also fear not being worthy. However, members of the church are invited to share the message of L'Arche through encounters with persons with mental illness. The church is invited to claim that persons with mental illness are precious. They are important. In these conversations, persons with mental illness may be transformed, but members of the church are also transformed.

Listening to the stories of others who are typically considered weak forces those who typically fit the norms of health, wealth, and beauty to face their own weakness. It is through this confrontation with the deepest self that Vanier hoped the church might form community with the weak. When all members of the body are together, the church begins to realize that an individualized Christianity is

insufficient. All persons are weak in some way. All followers of Christ cannot make it alone. The parts of the body need each other.

Vanier (2008) has provided an image of the church gathered as a community, living, eating, and celebrating together, each person accepted and loved as they are. Using I Corinthians 12 as his model, where the “weak” and “less honorable” are treated with greater honor and value, he encouraged the church to embrace those on the other side of the wall, to be with lepers, prostitutes, outcasts, and the weak. The church that welcomes the weak and vulnerable lives out the mission of an inclusive, rejoicing community, bound together in love. The body of Christ becomes more human through encountering the God whose work is revealed in weakness. As all members of the body of Christ are present and belong, the church can learn to do life together.

**Toward a theological understanding of mental illness.** C.S. Lewis (1949) said that, “There are no *ordinary* people. You have never talked to a mere mortal...Next to the Blessed Sacrament itself, your neighbour is the holiest object presented to your senses” (p. 46). Neighbors include persons with mental illness. It is an awesome thing to be called to share, even carry, another person’s burden, to be a friend (Lewis, 1949; Reinders, 2008). It is a gift of grace to be called to walk alongside another person in the wilderness, which is not an entirely bad place (Young, 2007). It is a place where one meets God in the darkness and recognizes

God's unfathomable depths (Young). It is through giving and receiving the gift of friendship, through recognizing our weakness as others reveal their weakness to us that we see the everlasting impact of how we treat each other (Gaiser, 2008; Lewis, 1949; Vanier, 2008).

Whether power, health, or ability, the things that often produce division between persons do not ultimately define what it means to be human (Vanier, 2008). Instead, it is the glory of the *imago dei* that defines human beings, and this mystery is found and extolled in weakness (Lewis, 1949; Vanier, 2008). Humans are born weak and in need of each other. As Lewis claimed, we are called to shoulder the struggles and afflictions of our neighbor, including those we may not love out of natural or self-interested instinct. It is our greatest responsibility in this life, the "weight of glory," as the title of one of Lewis' text suggests. In the body of Christ, each part is weak and cannot function without the other. As a whole, the body of Christ is defined as a people who suffer with those who suffer, and rejoice with those who rejoice.

**God as stranger.** While addressing disability, Young (2007) also expanded her biblical scholarship to address anything that makes one a stranger or outcast within the Christian community. She focused on the calling of the church to be aliens and exiles (I Peter 2:11), recalling the Israelite story of wandering in the wilderness, living in exile, and being on a pilgrimage. As the church carries on this

story, it is especially important to consider the aliens, exiles, and strangers within our communities, including persons with mental illness.

Young (2007) referred to a paper delivered by Reverend Ian Cohen in 1986 regarding the term *gér*, or “resident alien” found in the Hebrew Scriptures. He considered the expression more apt when talking about permanent disabilities. To be a *gér* means to be a sojourner, one from another clan or tribe who is brought under the protection of another community, having been cast out of one’s home. Many persons with mental illness fall into this category of those whose condition cannot be changed, who are cast out and excluded from mainstream society because of their illness. Mental illness is a lifetime condition for many people. They are the ultimate resident aliens in a society that projects security in wealth, beauty, and health (Vanier, 1998, 2008).

Recalling the Israelite story of wandering in the desert for 40 years, Young (2007) claimed that to be a *gér* is the essential identity of the Israelites, not only as sojourners but also as a people who identify with others who are aliens and strangers. She also noted that God commanded Israel to love the *gér* as one of them because God loves all persons, whether alien or tribe member. One example of this commandment in action includes Rahab, who was grafted into the community and was counted among one of Jesus’ ancestors.

Young (2007) also encouraged the church to see God as the ultimate *gér*, subtly proposed in Jeremiah 14:8. As she explained, the prophet represents the person who is on the outskirts, who is different, a true stranger. The prophet is the sign of Israel's identity when she strays from being a *gér* and embodies the strangeness of God, the God who is completely Other. Although Israel's identity and belongingness is wrapped up in being the *gér* just as God is the *gér*, Young stated that, "there is a belonging which is also a not belonging" (p. 89). Even while Israel belongs to God, God is still a stranger.

Like Young, Vanier (1998) also discussed persons who might be considered strangers in relating the story of the Good Samaritan. He noted that it was the one who would be considered a stranger who took care of the wounded man lying in the road. The community who should have helped the man stayed away. Vanier stated, "It is clearly this stranger, the good Samaritan, who sees the wounded man as a neighbor, who treats him as a neighbour, and who behaves as a neighbour should do" (p. 66). In this story, Jesus illustrates how Israel has strayed from being the *gér* and welcoming the *gér*. Instead, it is the literal stranger who shows Israel how to once again be the *gér*, to love all persons regardless of their place in this world, healthy or sick, insider or outsider.

Vanier (1998) also spoke about God's strangeness, how God can never be completely known. While we may experience God in a way that fills us completely,

that experience is also incomplete. It is a paradox. We may know God and yet not know God. Our knowledge will never be complete. Even as God reveals Godself to us, God will always remain a stranger to us in some sense. God also identifies with the strangers among us. God's people were strangers in a foreign land, and God was with them. Persons with mental illness can sometimes be strangers in the church, and yet God sees them, identifies with them, and calls them into community through the people of God. It is the responsibility of the church to bring in the alien and the stranger and to dwell together as a body.

To see God as a stranger is to also recognize that we need to seek after people who are outcasts, just as we continually seek after God. In the same way that we want to know God more through the grand narrative of Scripture, the church should also want to know more about persons with mental illness, to hear their stories. In that way, the otherness and the fear of the stranger may instead become understanding and love. To put a face to mental illness can reduce stigma (Corrigan & Penn, 1999). To see God in a human stranger is to experience communion with God and with each other more deeply. As Young (2007) claimed, the church is called to love the stranger with mental illness because the church is also a *gér*. The church needs to see the *gér* in the person with mental illness in order to recognize its own place in this world as an alien and a stranger.

***Humanness.*** According to Vanier (1998), to be human is to be connected and to belong. We all have the need to be loved, to be accepted for who we are, in all our strengths and weaknesses, and to also love, accept and celebrate other persons in all their strengths and weaknesses. Our task on this earth, toward becoming human, is to recognize the world around us as it is, in all its brokenness, and seek awareness, understanding, love, and belonging for all persons, especially those who are unseen and unloved. Lewis (1949) also saw this call toward recognition of and care for the weak when he spoke about the ultimate end of each of us. Each of us will be called upon to account for our treatment of each other, especially those we might be tempted to ignore.

Vanier (1998) often mentioned the impact of childhood experiences upon adult reactions to the world around them. Whether through lack of love or neglect or abuse, persons who experienced traumatic childhoods know what it is to be lonely. According to Vanier, the essence of loneliness is the feeling of being unwanted and unloved. Via internalized self-stigma, one might then believe that one is unlovable. In some cases, it is believed that trauma can lead to mental illness ([NAMI], 2012). This means that persons with mental illness, who are excluded from the church for not fitting the norm, may experience loneliness and rejection and feel both unloved and unwanted.



For Vanier (1998), people who have been hurt need to know that they belong before healing can take place. Healing occurs in relationship with others. Persons with mental illness move toward recovery when they are seen and heard and have a friend to walk alongside them. Like the stories in the Gospel of Mark, healing is not always automatic, and God is not a magician. Healing takes time and investment in mutual relationships of trust, to be in communion with each other.

Accordingly, Vanier's (1998) definition of humanness is located in communion. This requires trust, belonging, vulnerability, openness, and the ability to be oneself. Communion calls us to invite the heart of the stranger into our hearts and to have our hearts accepted into the heart of the stranger. Vanier claimed that some people dismiss the heart as a sign of weakness and emotion in favor of knowledge, intelligence and performance. However, to see and accept another person's heart is to see and accept each other's essential humanness. Communion located in the heart reveals the beauty in each person.

Communion that is found in relationships of trust involves acceptance of weaknesses in each other. When people are loved with all their weaknesses, then healing from loneliness and rejection can begin. Feelings of unworthiness begin to transform into acceptance for all that we are. Vanier (1998) asserted that weakness and belonging are intricately related. He said that when we attempt to ignore the reality of weakness, we live in denial of death. We are powerless in the face of death,

just as we are weak and powerless when we experience stigma or marginalization through the experience of mental illness. Death and illness seem to be antithetical to life, and so it is all too easy to ignore and deny the reality of weakness and suffering.

Vanier (1998) strongly criticized a sterile civilization that refuses to see or accept anything that is not pretty. As he said, we are afraid of things that are “dirty” (p. 80). Particularly in a society that is obsessed with youth, beauty, and vitality, people who may be considered “dirty” through non-normative behavior, appearance, and health are scary. Vanier also claimed that, “Fear is at the root of all forms of exclusion” (p. 71). We are afraid of things and people who are different, and in order to maintain a sense of security, we exclude persons with mental illness.

The safety of our well-ordered worlds is disrupted when we unearth the shared humanity between persons on the inside and on the outside (Vanier, 1998). It is disconcerting and dangerous for persons who fit societal norms to discover that they are not so different from persons they would ordinarily ignore and exclude. Vanier claims that those who are healthy, wealthy, and beautiful hold power over those who do not belong, according to society’s values. In order for communion to occur between persons who are acceptable in society and those who are excluded, those on the inside must let go of some of their power. At the same time, those who are healthy, wealthy, and beautiful must also address what Vanier calls the

“shadow side in ourselves” (p. 49). This includes all of our weaknesses, hurts, and the darkness that resides within us and in society. To begin to relate to the excluded person means leaving the safety of a world with barriers into a world of uncertainty, where we come into contact and relationship with those who are not a part of the sanitized world that society has established for those in power.

***Life together.*** According to Bonhoeffer (1954), when Christians dwell in true communion, no one who has Christ within him or her is excluded from the community. To ignore someone in our midst may mean to ignore Christ, just as in the parable of Matthew 25 where the king recognizes those who took care of the least of these, even while not recognizing that in doing so, they were indeed caring for Christ. As Bonhoeffer said, “The exclusion of the weak and insignificant, the seemingly useless people, from a Christian community may actually mean the exclusion of Christ; in the poor brother Christ is knocking at the door” (p. 38). Christ dwells in persons we deem insignificant, and in an inclusive fellowship, we may have communion with the triune God. We too dwell in Christ, and it is because we belong to Christ that we belong to each other.

Just as Lewis, Vanier, and Reinders would later recognize, Bonhoeffer held a clear vision of Christian community even while hiding from the Nazis with a small community of pastors in 1935. He claimed that, “The elimination of the weak is the death of fellowship” (p. 94). Every member of the community is indispensable. We

are all part of one interdependent body. We might extrapolate that his vision of Christian community provides an example of how the church today should stand against the exclusion of others based on difference that appears in the form of weakness.

Life together is messy, and it may involve conflict. In the L'Arche community, people get frustrated with each other. People argue and hurt each other. Vanier mentioned occasions when he had to admit his failings and the ways in which he harmed others in his community (1998). The vision of life together is not sentimental. Life together is not a utopia. It recognizes the challenges of being the body of Christ and how prone we are to say that we do not need each other. Persons with mental illness are often on the outskirts of the church because it can be challenging to be in relationship with persons who may struggle and act out in ways that hurt others.

Life as a member of the body of Christ may also mean humbly accepting our limitations as finite creatures to help one another. In some cases, because of our limitations, it may be necessary that relationships change. In a memoir that interweaves stories of his personal and professional life, Hauerwas (2010) spoke candidly about life together with his former wife, Anne, and the pain that both he and Anne experienced in their marriage. The text presents a stark image of what it looks like to be a family member and caretaker of a person with mental illness.

While the goal of life together is fellowship, Hauerwas offered an image of what life together can become without appropriate boundaries. Hauerwas took a step toward becoming more human the moment he realized that he could not save Anne, and he stepped away from the marriage for the sake of his own health. In my own life, I have lost friends because of my behavior. Sometimes it is only through separation that healing can occur.

Even when we cannot and should not live together in the same geographical space, God reminds us over and over that we are a people. We are God's people. We are a part of God's house, and that house may have periods of stress or confusion. We must realize that we cannot save each other. That is not our role, even if we think we are strong. The parts of the body need each other, weak and strong, but it is through stories like Hauerwas' that we see the parts of the body need each other in different ways. We may not be able to live in the same rooms, but God looks over this entire house. For all of us, God is our home.

### **Conclusion and Suggestions for Further Work**

The qualitative study conducted in this research demonstrates the importance of making mental illness visible through the faces and stories of real people who may have previously been unseen. Perceptions and attitudes toward mental illness and the persons it affects can and do change when we connect a face and a story to an otherwise shameful issue in the church.

Through stories, personal encounters, and developing relationships, we may recognize that a person with mental illness is a human being, not an illness. A person with a mental illness is made in the image of God, and mental illness is only a part of their story. That story may be painful; just as all lives involve suffering. However, it is through story that we connect and become more human. The church can change. It does not need to be a place that encourages silence around things that make us uncomfortable. Persons with mental illness and their families should not hide in the pews or avoid the church altogether. Mental illness does not need to be a taboo.

The literature review and qualitative study provide a framework for future study on perceptions and attitudes of laypersons in the church. While empirical literature on the perceptions and attitudes of clergy was not addressed in this thesis, research that has been conducted in this area could be supplemented by qualitative data. The literature has shown that denominational beliefs regarding mental illness frequently differ from the perceptions and attitudes of laypersons (Hartog & Gow, 2005). In speaking with church leaders, the question might be broached as to how clergy and denominational leaders might openly address this issue from the pulpit.

In addition, the theological analysis suggests that continuing research on a theology of mental illness should not be siloed. Speaking about mental illness in the church is not a side project or a special ministry. It affects the entire body of Christ.

Based on the work already conducted in disabilities studies, a fully fleshed theology of mental illness could address the fact that many persons in the church experience marginalization. Continued theological research on mental illness could emphasize Christ's mission to bring good news to the poor, proclaim release to the captives and recovery of sight to the blind, to let the oppressed go free, to proclaim the year of the Lord's favor (Luke 4:18-19, NRSV).

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## Appendix A



Dear College/20s/30s Community Group member,

I am a graduate student in Seattle Pacific University's theology program. I am running a study for my master's thesis. I plan to explore perceptions and attitudes of people who attended the Sunday School teaching series on mental illness I taught last April. The goal of my study is to learn about the effect or impact of a Sunday School teaching on perceptions of mental illness.

I am seeking volunteers from people who attended the series on mental illness. I am asking you to take part because you attended the series. Since we developed a relationship in a ministry setting, you may choose not to take part in this project with me, and that is perfectly acceptable.

If you choose to take part, I will schedule an interview with you. As the principal investigator, I will ask questions about your personal experiences of the teaching series. The interview will take about one hour. When you are able to meet with me, I will schedule the interview in a private conference room or university office.

Overview about Participation and Confidentiality:

- **Your participation is completely voluntary.** You may decide not to take part and leave at any time before or during the interview. You may also choose not to answer any particular question.
- If you agree to take part, you will meet with me for an interview. I will use a tape recorder to be sure that I accurately record your responses. However, I will tell you before the interview to avoid stating your name, your address, or the names of any other class participants to maintain high levels of confidentiality.
- The results of this study will be used to meet graduate degree requirements at Seattle Pacific University. I will report the data from every person who takes part in a research paper. I will not include any personal information and will protect your identity. Your answers will be used only for my study or for educational purposes.
- There are no direct benefits to you for taking part in this study. However, you may benefit from thinking about your experience in the class. There are no known risks for taking part in this study. However, if any of the questions make you feel uncomfortable, please feel free not to answer. You may also stop the interview at any time.
- Your privacy and the research records will be kept confidential. Information from taped recordings will not include your personal information. I will keep the tape recordings in a locked safety box. Only I have access to the safety box. I will use the data I collect from your answers to complete degree requirements at Seattle Pacific University. I may use the data in future writing and/or speaking.
- This research study has been reviewed and approved by the SPU Institutional Review Board (IRB # 131404006; valid through March 4, 2015). Questions or concerns about your rights may be directed to the SPU IRB office (206.281.2201) or to the faculty advisor listed below.
- If you are interested in taking part in this study, please contact Megan Hamshar at (206)281-2378 or [mego@spu.edu](mailto:mego@spu.edu). The SPU professor overseeing this research is Dr. Marcia Webb. She can be reached at [marcia@spu.edu](mailto:marcia@spu.edu).

Sincerely,

Megan Hamshar

## Appendix B

**Principal Investigator:** Thank you for meeting with me. Before we begin, I want to go over the informed consent with you and answer any questions or concerns you may have.

Answers questions or concerns and have participant sign the informed consent.

**Principal Investigator:** I want to remind you that I will use an audio tape recorder while we talk. This allows me correctly write up our interview to put in my research. Before we begin, I want to remind you to avoid saying your name or the names of any people who attended the teaching series. This will protect your privacy and the privacy of other people. Do you have any questions or concerns?

**Participant:** Responds yes or no. If yes, explain further. If no, continue with interview.

**Principal Investigator:** Ok great. I'm now going to turn on the tape recorder and we will begin our interview:

**Participant:** answers questions\*

1. Participant #\_\_ Can you verify that you attended all four sessions of the teaching series?
2. What were your attitudes and perceptions of mental illness prior to the teaching series?
  - a. Can you give an example of an event or experience that showed this attitude?
3. What are your attitudes and perceptions of mental illness following the teaching series?
  - a. Can you give an example of an event or experience that showed this attitude?
4. What do you believe are the attitudes and perceptions of mental illness in the church as a whole?
  - a. Can you give an example of an event or experience that showed this attitude?
5. What elements of the teaching series increased your understanding of mental illness, if any?
6. What elements of the series were particularly helpful, if any?
7. In what ways could the teaching series improve?
8. Were any important subjects not addressed? If so, what subjects?
9. If you feel comfortable sharing, were any elements of the teaching series hurtful?
10. Do you recall a moment that was particularly impactful, either positive or negative?
11. What does the term "mental illness" mean to you today?
12. What has the term "mental illness" meant to you in the past?
13. Is there anything else regarding mental illness or the Sunday School series that you believe is important for me to know?

\*Principal Investigator may elicit more details depending on participant's answers by stating:

Can you expand on that?  
 Can you give me an example?  
 How did that make you feel?

If answering questions provoke negative emotions to participants, principal investigator will respond by stating:

Would you like to take a little break?  
 We can skip this question if it makes you uncomfortable.  
 Would you like to stop here and discontinue?

At end of interview, principal investigator will thank participants for their time and cooperation.



**Appendix C**

Approved IRB Application

February 14<sup>th</sup> 2014

Dear Megan Hamshar & Marcia Webb,

Thank you for your IRB application, *Perceptions & Attitudes of Mental Illness among Participants in a Sunday School Teaching Series on Mental Illness*. Your protocol has been approved under expedited review as it met the requisite criteria under 45 CFR 46.101.

Your study has been assigned IRB number **131404006**. This study number and your **expiration date of March 4, 2015** must be included on all documents relating to your study, including your consent and recruitment materials. I have used campus mail to return a stamped copy of your consent to you for use in your study.

Please contact me when you have completed collecting data for your study so that I can close your file. If you need to make any changes or revisions to your protocol, you must notify me. Your request for approval of changes must include a report on the status of your study ([www.spu.edu/orgs/irb](http://www.spu.edu/orgs/irb)) and your approved IRB application with the requested modifications highlighted. Please use your IRB study number in any further communication regarding this study.

Best wishes in the completion of your research. Please don't hesitate to contact me if I can answer any questions or assist you in any way.

Sincerely,

*Susan Casey*  
IRB Member

Susan Casey PhD, RN  
Associate Dean, Graduate Nursing  
206-281-2649 or caseys@spu.edu

IRB # 131404006  
Expiration Date 3-4-15

**SEATTLE PACIFIC UNIVERSITY  
IRB APPLICATION FOR HUMAN SUBJECTS REVIEW**

Title of project: **Perceptions and Attitudes of Mental Illness among Participants in a Sunday School Teaching Series on Mental Illness**

Expected Start Date for Data Collection: **February 2014**

Expected End Date for Data Collection:<sup>1</sup> **March 2014**

Name of Principal Investigator: **Megan Hamshar**

Phone #: **(206) 883-5463** e-mail<sup>2</sup> **mego@spu.edu**

Name of Co-Investigator(s)<sup>3</sup>: **Marcia Webb, Ph.D.**

Phone #: **(206)281-2683** e-mail **marcia@spu.edu**

Name of Co-Investigator(s): \_\_\_\_\_

Phone #: \_\_\_\_\_ e-mail \_\_\_\_\_

Faculty Sponsor Name: **Marcia Webb, Ph.D.**

Faculty Sponsor signature: \_\_\_\_\_ Date: \_\_\_\_\_

Research Coordinator: \_\_\_\_\_ Date received: \_\_\_\_\_

=====  
Directions: Submit **two typed hard copies** of the IRB application and research protocol / other material that will be given to participants to your Research Coordinator. It is estimated that the initial review process or any review of revisions will be completed within two weeks. Research that has more than minimal risk or includes vulnerable participants may be passed on to be reviewed by the entire Institutional Review Board (IRB) or a subset of members. If your study is passed on for further review, you will be notified. Please expect additional delays for expedited or full IRB review. **The IRB meets once each month between October and May so plan accordingly.**

**Complete all information:**

- 1. Purpose of study:** Provide specific and concise detail so that the IRB can match the procedure and informed consent to the purpose. If you include citations please add a reference section as an appendix.

**The body of research on attitudes and perceptions of mental illness in the church indicates that most congregants hold negative attitudes and perceptions of persons with mental illness. Teaching curricula may be impactful toward reducing stigma and shame around mental illness as well as increasing awareness, knowledge, and compassion.**

<sup>1</sup> The IRB generally approves studies for only one year duration unless the PI notes that the study is longitudinal and requires multiple years for completion. If your study is not longitudinal and you expect data collection to be less than one year but wish to continue collecting data beyond one year you must contact your IRB representative six weeks before the expiration date of your IRB application to petition for an extension of your study. If your study is approved from more than one year, you must provide a report regarding the progress of your study

<sup>2</sup> List SPU e-mails if SPU community member

<sup>3</sup> List all participating researchers. If PI is a student, the faculty / staff sponsor must be listed as a Co-investigator. List either e-mail or phone number for co-investigators

The church as a whole often lacks knowledge regarding mental illness, including its causes, historical treatments, media portrayals and relationship to violence, and the impact of mental illness upon daily functioning. In addition, Scriptural teachings frequently link the modern conception of mental illness with traditional and historical understandings of sin, lack of faith, or demon possession. Perceptions and attitudes toward persons with mental illness, then, may not invite inclusion and belonging.

The purpose of this prospective, qualitative study is to explore the perceptions and attitudes of participants in a Sunday School teaching series on mental illness, which was taught in April 2013 at First Free Methodist Church in Seattle. The goal of the study is to ascertain the possible effectiveness of a Sunday School curriculum in order to positively change perceptions of mental illness in the church as a means to overcome stigma and shame among persons with mental illness and their families within the church.

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## 2. Sample/population

- a. Describe the sample size and demographic requirements and location of recruitment for the participants. Explain the rationale for using this population. Note if you are using a special population such as prisoners, children, the mentally disabled or others whose ability to give voluntary consent may be in question.

**The sample population in this study will be a purposeful, convenience sample of 10 participants in a Sunday School teaching series which the primary investigator taught during April 2013 at First Free Methodist Church in Seattle. Inclusion criteria for participation in the study require that all subjects were participants in the four-week series.**

**The attitudes and perceptions of participants in the Sunday School series toward mental illness are relevant to understanding the perceptions of the church as a whole. Since this subject is not typically openly addressed in the church, the individual stories of participants may be impactful upon the church as a whole as it is openly discussed and supported by existing data and anecdotal reports on common perceptions and attitudes toward mental illness in the church.**

- b. Who will recruit subjects and how? Ensure that you include any written recruitment material or verbal scripts of oral recruitment statements.

**Subjects will be recruited by the volunteer coordinator of First Free Methodist Church via an email to all participants in the April 2013 Sunday School teaching series at First Free Methodist Church.**

**Subjects will also be made aware of the study purpose, intent, and parameters. Participation is voluntary and no compensation will be given. One reminder email will be sent to potential participants one week after the initial contact. (See Appendix A for recruitment email and Appendix B for reminder email).**

- c. Identify steps taken to avoid coercion including dual relationships (i.e., faculty/staff, therapist/client).

**This study will involve dual relationships. The principal investigator is both a staff member and student at Seattle Pacific University. Participants in the Sunday School teaching series also include staff and students at Seattle Pacific University. The principal investigator will avoid coercion by providing clear indication that this is a voluntary study. Potential subjects are free to decline to take part without penalty. (See Appendix A).**

### **3. Research Procedure**

- a. Describe the materials, measures and / or, apparatus that you will use for this study. Attach the materials that you are going to use in the exact format that participants will receive
1. Include any recruitment material (both written and scripted for verbal instructions).
  2. If you are using a web-based survey, include the screen shots of the material.
  3. If you are using any type of coding protocol, include a copy of your coding sheet.
  4. If you are using questionnaire, include a copy in the exact format that the participants will use.
  5. If you are using copy-written material provide documentation that you have permission to use or reproduce the material for your study.
- b. Describe in detail the research procedure and / or protocols. Ensure that you explain in an active verb tense a) where, b) when, c) how the data will be collected and d) by whom.<sup>4</sup> If you are conducting a study with an intervention, provide written instructions, transcript of verbal instructions and any other protocol. Identify any procedures that are experimental with potentially unknown risks or outcomes.

**The principal investigator will recruit participants through an email about the study, which will be sent by a member of the church staff. The principal investigator's contact information will be included in the email. Participants interested in partaking in the study will contact the principal investigator either by email or phone. The principal investigator will then set up an appointment in a private conference room or university office for one-on-one interviews at a time convenient to the participants.**

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<sup>4</sup> Rather than stating that informed consent will be gathered write how you will collect informed consent.

**The principal investigator will review the purpose of the study with each participant and ask the participant to read and sign the consent form. The PI will answer any questions or concerns about the study. Participants will be ensured that participation is completely voluntary and that they have the right to take a break, skip a question, or to drop out at any time.**

**Before the interview, the principal investigator will instruct the participants to avoid stating any identifying information, including their name, address, and employer. The participants will also be informed not to mention the names of other participants in the Sunday School series. The participant's signature on an informed consent form must be provided before the interview takes place (a copy of the consent form will be provided to the participant). During the interview, questions will be guided by the scripted interview questions.**

**The principal investigator will utilize an audiotape recorder to openly record the interview for data collection purposes. Confidentiality will be maintained throughout the process. Audiotapes and transcribed tapes will be coded from numbers 1 through 10 for tracking purposes.**

- c. Are you planning to use the research data for other activities / research outside of this study? If so, are other uses clearly labeled in the confidentiality section of the informed consent form?

**Research data will be used for Seattle Pacific University requirement purposes in the Master of Arts in Theology graduate program and may be used in future research, writing, or speaking engagements. This disclosure is included in the confidentiality section of the informed consent form.**

#### **4. Time Frame**

What is the total time that participants will spend in this study? If participants will give data multiple times, how long will they spend in each session and how many sessions will they participate in?

**It is estimated each participant will spend about one hour in a single session answering interview questions.**

#### **5. Risks**

- a. Describe and assess any potential risks--physical, psychological, social, legal or other--and assess the likelihood and seriousness of such risks.

**The potential risks of answering interview research questions should be minimal to none. However, answering questions about the experiences of a teaching on mental health may possibly bring about mild negative emotional experiences to participants but are expected to be very transient in duration and self-limiting in nature.**

- c. If methods of research create potential risks, describe other methods, if any, that were considered and why they will not be used.

**Due to low potential risk for this study, other methods were not considered to reduce risks.**

- d. Describe procedures, including confidentiality safeguards, for protecting against or minimizing potential risks and an assessment of their likely effectiveness.

**Interviews will be conducted during an agreed upon time in a private conference room or university office.**

**If mild emotional distress occurs, participants will be asked if they wish to discontinue participation or take a brief break. Participants will also be informed that they may choose not to answer any particular question or to discontinue the interview.**

**All participation or nonparticipation will be kept confidential and not shared with anyone outside of the educational requirement purpose.**

## **6. Responsible Conduct of Research**

- a. If you are applying for a NSF or NIH grant,
- b. If there is more than minimal risk or;
- c. If you are collecting data from children outside of normal activities,
- d. You are collecting data from prisoners or other vulnerable populations including pregnant women, neonates or others who may be vulnerable to coercion in providing their informed consent.<sup>5</sup>

**Not applicable.**

**Benefits:** Assess the potential benefits that may be gained *by any individual participant*, as well as benefits which may accrue to society in general as a result of the planned work. Specify any compensation such as monetary or academic credit that you may offer as part of the study.<sup>6</sup>

**There is no direct benefit to participants. However, participants may experience slight benefit from reflection and exploration of their experience in the Sunday School series. A small benefit to the church may exist from the knowledge gained from this study that can potentially help the church community understand and change current perceptions of mental illness in the church.**

<sup>5</sup> As per 45CFR46 subpart B, C & D

<sup>6</sup> Ensure that the informed consent only lists the benefits the individual participants can expect from the study.



## 7. Confidentiality:

- a. How will you maintain the confidentiality of participant information?

**The principal investigator will take all necessary measures to prevent collecting personal identification information. There will be no identifying information retained in this study. Contact information will be collected through email exchanges and kept confidential, as it is password protected. Once the interview is completed, the PI will delete emails containing contact information.**

- b. How and where will you store the raw and /or electronic records for the three years that SPU requires data and other research records to be stored?

**The tape recordings of the interview will be stored in a locked box that only the principal investigator will have access to while being transcribed and verified. Then the tapes will be destroyed and transcripts, with the signed consents placed inside a sealed envelope separate from the transcripts, will be stored in Seattle Pacific University's School of Theology office for the three years that SPU requires data and other research records to be stored.**

- c. If the data is subject to HIPAA, how will you de identify medical data?

**Not applicable. Medical data will not be used.**

8. **Funding:** Federal regulations require the establishment of policies to manage conflicts of interest as they relate to human subjects research. The IRB recognizes that many research projects have the potential for actual or perceived conflicts of interest. The IRB is mandated to protect subjects from financial conflict of interest which may predispose coercive enrollment practices or the possibility of reporting biased or inaccurate data. The intent of the following guidelines is to protect research subjects and their families and to delineate the responsibilities of the researcher.

- a. Researchers must include with their application materials all information about a financial relationship with a sponsor. This includes a copy of a grant award, contract, budget, and equity interest documentation.
- b. If you propose to provide an incentive for participation or to reimburse subjects for expenses of participation, you must include this information with a budget explication. Payment to research subjects for participation in studies is not considered a benefit, it is a recruitment incentive. The amount and schedule of all payments should be presented to the IRB at the time of initial review. The IRB will review both the amount of payment and the proposed method and timing of disbursement.
- c. If the contract, budget or equity interest changes during the research project, the researcher must notify the IRB. This includes the termination of a contract, a supplement to a contract, or an extension.

**Not applicable. This is an unfunded student research project.**

## 9. Consent Documentation

- a. Describe consent procedures to be followed, including how and when documented informed consent will be obtained vis a vis the rest of the data collection procedure. Ensure that it is clear to the participant that SPU is the sponsoring institution and that the language used in the informed consent is clear and can be easily understood by the participants.<sup>7</sup>

***If you have a documented informed consent or assent you must complete the consent checklist on the next page and include it in your application package for each consent or assent form.***

**Please note: All hard copies of informed consent will be stamped by the IRB upon approval. Only stamped IRB consent forms [and recruitment posters] can be used by the PIs.**

**In the event of electronic informed consent (e.g. electronic survey), the SPU IRB # and expiration date must be included**

**Participants interested in partaking in the study will contact the principal investigator either by email or phone. The principal investigator will then set up an appointment in a private conference room or university office for one-on-one interviews at a time convenient to the participants. The principal investigator will review the purpose of the study with each participant and ask the participant to read and sign the consent form. The PI will answer any questions or concerns about the study. Participants will be ensured that participation is completely voluntary and that they have the right to take a break, skip a question, or to drop out at any time.**

- b. If working with vulnerable populations (children, prisoners, pregnant women, mentally ill or any other participants who may have difficulty giving informed consent) describe how consent or assent will be obtained?

**Not Applicable.**

- c. If documented informed consent will not be obtained, specifically point this out and explain how you will communicate to participants' information they need to make an informed decision to participate in the research. Provide a copy of any invitation to participate in research which spells out the participants' rights and responsibilities even if they are not providing documented informed consent.

**Not Applicable.**

10. Deception: If any deception (i.e., withholding of complete information) is required for the validity of this activity, explain why this is necessary and attach debriefing statement.

**Not Applicable.**

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<sup>7</sup> You are strongly encouraged to use the informed consent template found at the SPU IRB website. You may tailor the language to provide appropriate reading level for your participants. You must ensure that all required elements are included in your informed consent as appropriate.

## Informed Consent Required Elements Checklist

Complete if you have documented informed consent as part of your study  
(Type **NA** if item is not applicable to your study.)

Provide the reading level associated with the informed consent. Is this level appropriate for the participants?  
**8<sup>th</sup> grade reading level. Yes.**

### Investigators

- Consent forms must state **who is conducting the research**, provide contact information for anyone who will collect data and clearly labeled that the research is sponsored by SPU. The IRB encourages the use of SPU logo or letterhead.

### Purpose

- Use of word "study," "research," "evaluation" or "investigation" to describe activity
- An informed explanation of the **purpose** of the research
- Explanation for why the participant was invited to participate in the study
- Number of participants expected to participate in the study

### Procedures

- A description of the **procedures** to be followed
- Identification of any **experimental treatments, procedures, or devices (NA)**
- A disclosure of any appropriate **alternative procedures** or courses of treatment **(NA)**
- The **location(s)** where the procedures will be done
- The expected total **duration** of participation and that of each phase of multi-phase protocols

### Risks

- A description of the reasonably foreseeable **risks** and discomforts, or a statement that the research does not involve risks beyond those encountered in everyday life, as appropriate.

### Emergency Medical / Psychological Treatment

- Studies involving exercise testing or supervised physical activity include emergency policies and procedures. **(NA)**
- An explanation of any **costs** to the subject for research-related procedures, hospital stays, use of equipment, lost compensation or insurance, or extraordinary transportation requirements **(NA)**
- As appropriate, an explanation as to whether any **compensation** or **medical treatment** is available if injury occurs, what it would consist of (if any), or where further information may be obtained. **(NA)**

### Benefits

- A description of possible direct **benefits** to each subject, which may reasonably be expected from the research, or a statement that individual subjects may not directly benefit from participation though there may be benefits to general knowledge or to society.

### Confidentiality

- A statement describing the extent to which **confidentiality** of records identifying subjects will be maintained, including who will have access to and the methods for securing such records.

### Compensation

- An explanation of any **gratuities** for participation and, if appropriate, procedures to **prorate** amounts for subjects who withdraw before completing the research protocol **(NA)**

### Who to Contact

- The name(s), title(s), local toll-free telephone number(s), and e-mail addresses of the **person(s) to contact for answers to questions about the research**, including those for the responsible project investigator, if different
- An invitation to contact the **IRB Office** (IRB@SPU.edu) for **information about the rights of human subjects** in SPU-approved research.
- As appropriate, the name(s), title(s), and daytime and evening telephone number(s) of the **person(s) to contact in the event of a research-related injury, adverse effect, or complaint**

### Participation and Alternatives to Participation

- A statement that participation is **voluntary**
- A statement that **subjects may refuse to participate or may discontinue participation** at any time during the project without penalty or loss of benefits to which they are otherwise entitled
- For surveys and interviews, a statement that subjects may **skip any questions** they don't wish to answer

No language through which subjects are made to **waive** any **legal rights**, including any release of the university or its agents from liability or negligence

**Near the Signature Line**

A statement that **participants will be given a copy** of the consent form

**After IRB Approval**

SPU IRB number and expiration date are placed on informed consent and any other recruitment material.

**Please note: All hard copies of informed consent will be stamped by the IRB upon approval. Only stamped IRB consent forms [and recruitment posters] can be used by the PIs.**

**In the event of electronic informed consent (e.g. electronic survey), the SPU IRB # and expiration date must be included**



## Appendix A Email Recruitment Letter

Dear College/20s/30s Community Group member,

I am a graduate student in Seattle Pacific University's theology program. I am running a study for my master's thesis. I plan to explore perceptions and attitudes of people who attended the Sunday School teaching series on mental illness I taught last April. The goal of my study is to learn about the effect or impact of a Sunday School teaching on perceptions of mental illness.

I am seeking volunteers from people who attended the series on mental illness. I am asking you to take part because you attended the series. Since we developed a relationship in a ministry setting, you may choose not to take part in this project with me, and that is perfectly acceptable.

If you choose to take part, I will schedule an interview with you. As the principal investigator, I will ask questions about your personal experiences of the teaching series. The interview will take about one hour. When you are able to meet with me, I will schedule the interview in a private conference room or university office.

Overview about Participation and Confidentiality:

- **Your participation is completely voluntary.** You may decide not to take part and leave at any time before or during the interview. You may also choose not to answer any particular question.
- If you agree to take part, you will meet with me for an interview. I will use a tape recorder to be sure that I accurately record your responses. However, I will tell you before the interview to avoid stating your name, your address, or the names of any other class participants to maintain high levels of confidentiality.
- The results of this study will be used to meet graduate degree requirements at Seattle Pacific University. I will report the data from every person who takes part in a research paper. I will not include any personal information and will protect your identity. Your answers will be used only for my study or for educational purposes.
- There are no direct benefits to you for taking part in this study. However, you may benefit from thinking about your experience in the class. There are no known risks for taking part in this study. However, if any of the questions make you feel uncomfortable, please feel free not to answer. You may also stop the interview at any time.
- Your privacy and the research records will be kept confidential. Information from taped recordings will not include your personal information. I will keep the tape recordings in a locked safety box. Only I have access to the safety box. I will use the data I collect from your answers to complete degree requirements at Seattle Pacific University. I may use the data in future writing and/or speaking.
- This research study has been reviewed and approved by the SPU Institutional Review Board (IRB # \_\_\_\_\_; valid through \_\_\_\_\_). Questions or concerns about your rights may be directed to the SPU IRB office (206.281.2201) or to the faculty advisor listed below.
- If you are interested in taking part in this study, please contact Megan Hamshar at (206)281-2378 or [mego@spu.edu](mailto:mego@spu.edu). The SPU professor overseeing this research is Dr. Marcia Webb. She can be reached at [marcia@spu.edu](mailto:marcia@spu.edu).

Sincerely,  
Megan Hamshar



## Appendix B Email Recruitment Reminder Letter

Dear College/20s/30s Community Group member,

I am a graduate student in Seattle Pacific University's theology program. I am running a study for my master's thesis. I plan to explore perceptions and attitudes of people who attended the Sunday School teaching series on mental illness I taught last April. The goal of my study is to learn about the effect or impact of a Sunday School teaching on perceptions of mental illness.

I am seeking volunteers from people who attended the series on mental illness. I am asking you to take part because you attended the series. Since we developed a relationship in a ministry setting, you may choose not to take part in this project with me, and that is perfectly acceptable.

If you choose to take part, I will schedule an interview with you. As the principal investigator, I will ask questions about your personal experiences of the teaching series. The interview will take about one hour. When you are able to meet with me, I will schedule the interview in a private conference room or university office.

Overview about Participation and Confidentiality:

- **Your participation is completely voluntary.** You may decide not to take part and leave at any time before or during the interview. You may also choose not to answer any particular question.
- If you agree to take part, you will meet with me for an interview. I will use a tape recorder to be sure that I accurately record your responses. However, I will tell you before the interview to avoid stating your name, your address, or the names of any other class participants to maintain high levels of confidentiality.
- The results of this study will be used to meet graduate degree requirements at Seattle Pacific University. I will report the data from every person who takes part in a research paper. I will not include any personal information and will protect your identity. Your answers will be used only for my study or for educational purposes.
- There are no direct benefits to you for taking part in this study. However, you may benefit from thinking about your experience in the class. There are no known risks for taking part in this study. However, if any of the questions make you feel uncomfortable, please feel free not to answer. You may also stop the interview at any time.
- Your privacy and the research records will be kept confidential. Information from taped recordings will not include your personal information. I will keep the tape recordings in a locked safety box. Only I have access to the safety box. I will use the data I collect from your answers to complete degree requirements at Seattle Pacific University. I may use the data in future writing and/or speaking.
- This research study has been reviewed and approved by the SPU Institutional Review Board (IRB # \_\_\_\_\_; valid through \_\_\_\_\_). Questions or concerns about your rights may be directed to the SPU IRB office (206.281.2201) or to the faculty advisor listed below.
- If you are interested in taking part in this study, please contact Megan Hamshar at (206)281-2378 or [mego@spu.edu](mailto:mego@spu.edu). The SPU professor overseeing this research is Dr. Marcia Webb. She can be reached at [marcia@spu.edu](mailto:marcia@spu.edu).

Sincerely,  
Megan Hamshar

## Appendix C Recruitment Script

Interested participants may contact the principal investigator either by phone or email after receiving a recruitment email for the research project. If potential participants contact the principal investigator to inquire about participation in research study, this recruitment script will be utilized as follows:

**Principal Investigator:** Thank you for your interest in taking part in this study. Do you have any questions?

**Participant:** Responds yes or no. If yes, explain more clearly.

**Principal Investigator:** In order to take part in this study, you must meet certain requirements. This means that you must have attended in all four weeks of the teaching series. Do you meet the requirements? Do you have any questions or concerns?

**Participant:** Responds yes or no. If questions come up, explain more clearly.

If participant does not fit eligibility requirements, the principal investigator will respond by stating: Thank you for your interest in this study. However, you do not meet the eligibility requirements because you did not attend all sessions of the teaching series. If no questions and participant fits eligibility criteria, continue with recruitment script.

**Principal Investigator:** Let me give you an overview about what is involved with your participation. You will with me at a time that works for you for a one-time interview. I will reserve a private conference room or university office for our interview. I will ask you questions about your perceptions and attitudes of mental illness as you took part in the Sunday School teaching series on mental illness. The interview will be audio tape recorded. However, the recording will not include any personal information and will protect your identity. Your participation is voluntary. You can choose to cancel or stop at any time. You also can choose not to answer any particular question. I will have you sign an informed consent form. I will go over this with you when we meet in person. Do you have any questions?

**Participant:** Responds yes or no. If yes, explain further.

**Principal Investigator:** Would you be interested in participating in this study?

**Participant:** Responds yes or no.

If no, thank the individual for their time.

If yes, proceed with remainder of recruitment script.

**Principal Investigator:** Great! When would be the best time to meet for our interview?

**Participant:** Coordinates meeting place, date and time of one-on-one interview with principal investigator.

**Principal Investigator:** Thank you for your time. Do you have any other questions or concerns? Please feel free to contact me for questions or concerns. I look forward to meeting with you.

## Appendix D Scripted Interview Questions

**Principal Investigator:** Thank you for meeting with me. Before we begin, I want to go over the informed consent with you and answer any questions or concerns you may have.

Answers questions or concerns and have participant sign the informed consent.

**Principal Investigator:** I want to remind you that I will use an audio tape recorder while we talk. This allows me correctly write up our interview to put in my research. Before we begin, I want to remind you to avoid saying your name or the names of any people who attended the teaching series. This will protect your privacy and the privacy of other people. Do you have any questions or concerns?

**Participant:** Responds yes or no. If yes, explain further. If no, continue with interview.

**Principal Investigator:** Ok great. I'm now going to turn on the tape recorder and we will begin our interview:

**Participant:** answers questions\*

1. Participant #\_\_ Can you verify that you attended all four sessions of the teaching series?
2. What were your attitudes and perceptions of mental illness prior to the teaching series?
  - a. Can you give an example of an event or experience that showed this attitude?
3. What are your attitudes and perceptions of mental illness following the teaching series?
  - a. Can you give an example of an event or experience that showed this attitude?
4. What do you believe are the attitudes and perceptions of mental illness in the church as a whole?
  - a. Can you give an example of an event or experience that showed this attitude?
5. What elements of the teaching series increased your understanding of mental illness, if any?
6. What elements of the series were particularly helpful, if any?
7. In what ways could the teaching series improve?
8. Were any important subjects not addressed? If so, what subjects?
9. If you feel comfortable sharing, were any elements of the teaching series hurtful?
10. Do you recall a moment that was particularly impactful, either positive or negative?
11. What does the term "mental illness" mean to you today?
12. What has the term "mental illness" meant to you in the past?
13. Is there anything else about mental illness or the Sunday School series that you believe is important for me to know?

\*Principal Investigator may elicit more details depending on participant's answers by stating:

Can you expand on that?

Can you give me an example?

How did that make you feel?



If answering questions provoke negative emotions to participants, principal investigator will respond by stating:

Would you like to take a little break?

We can skip this question if it makes you uncomfortable.

Would you like to stop here and discontinue?

At end of interview, principal investigator will thank participants for their time and cooperation.

**Appendix E**  
**Letter of Support**



# FIRST FREE METHODIST CHURCH

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January 11, 2014

To whom it may concern:

This letter is to serve as an endorsement for a scholarly inquiry titled, *"Perceptions and Attitudes of Mental Illness among Participants in a Sunday School Teaching Series on Mental Illness"* conducted by Megan M. Hamshar. I understand and support that this project is in partial fulfillment of her Master of Arts in Theology degree from Seattle Pacific University. I understand that prior to any initiation of the scholarly inquiry, I will be provided with a copy of the approval from the Seattle Pacific University Internal Review Board Protection of Human Subjects. I understand that this project solicits volunteers and is to be implemented separate from all current employee position responsibilities and will not be conducted as paid work time. As senior pastor of First Free Methodist Church, I willingly support and approve this project to be implemented within this organization.

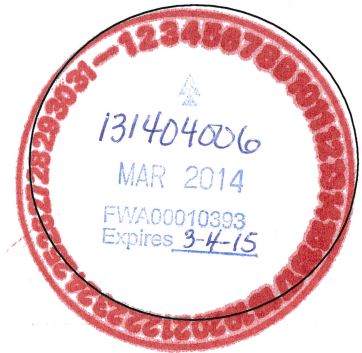
Sincerely,

Blake Wood, Senior Pastor  
First Free Methodist Church  
[blake@ffmc.org](mailto:blake@ffmc.org)



Engaging the culture, changing the world®

**Seattle Pacific**  
UNIVERSITY



## INFORMED CONSENT <sup>1</sup>

Perceptions and Attitudes of Mental Illness among Participants in a  
Sunday School Teaching Series on Mental Illness

### Investigators:

**Principal:** Megan Hamshar

Master of Arts in Theology candidate  
School of Theology  
(206)883-5463  
[mego@spu.edu](mailto:mego@spu.edu)

**Co-investigator:** Marcia Webb, Ph.D.

Professor of Clinical Psychology  
School of Psychology, Family, and Community  
(206)281-2683  
[marcia@spu.edu](mailto:marcia@spu.edu)

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### PURPOSE

You are invited to take part in a research study. The purpose of this study is to explore perceptions and attitudes of mental illness from people who attended a Sunday School teaching series taught last April. You are invited to take part in this study because you attended the teaching series. 10 people will take part in this study.

### AVOIDING COERCION DUE TO DUAL RELATIONSHIP

In order to run this study, a dual relationship cannot be avoided. However, the researcher and the faculty advisor will talk about how these relationships may affect how the information from your interviews is collected and the results from the interviews. This will be discussed in the final report.

### PROCEDURES

You will be asked questions about your experience in the teaching series on mental illness last April. The researcher will ask you about your attitudes and perceptions of mental illness before and after the teaching series. The researcher will also ask you about perceptions and attitudes of mental illness in the whole church.

You will be asked how the teaching affected how you understand mental illness. In addition, the researcher will ask you how the teaching series could improve. You may talk about anything that was not included and anything that was helpful or hurtful. You will also be asked whether you remember a moment that affected you, either good or bad. After these questions, you will be asked if you want to share anything else you believe is important for the researcher to know.

Should you choose to take part, the researcher will schedule an interview with you at a time when you are able to meet. The interview will take place in a private conference room or university office. The interview will last about an hour.

The researcher will use an audio tape recorder during the interview to be sure your answers are correctly recorded. Your privacy will be protected during the study.

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<sup>1</sup> See instructions at end of this document.

Audiotapes will not include your name or any other personal information.

Once the interview is over, you will be done with the study. If you wish to see the final report after it is published, you may contact the researcher.

#### **RISKS and DISCOMFORTS**

There are no known risks for taking part in this study. However, if any of the questions make you feel uncomfortable, please feel free not to answer. You may also stop the interview at any time.

#### **BENEFITS**

There are no direct benefits to you for taking part in this study. However, you may benefit from thinking about your experience in the class.

#### **PARTICIPATION AND ALTERNATIVES TO PARTICIPATION**

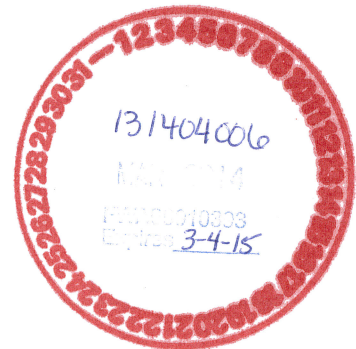
Taking part in this study is voluntary. You may decline this invitation. If you decide to take part, you may withdraw from the study at any time. If you withdraw from the study before the information from the interview is collected, the information from your interview will be returned to you or destroyed. The researcher may also stop your participation in the study at any time.

#### **CONFIDENTIALITY**

Your privacy and the research records will be kept confidential. Information from taped recordings will not include your personal information. I will keep the tape recordings in a locked safety box. Only I have access to the safety box. I will use the data I collect from your answers in a formal research write up. I will not include any personal information and will protect your identity. Your answers will be used only for my study. I may use the data in future writing and/or speaking.

#### **SUBJECT RIGHTS**

If you have questions at any time about the study, or if you experience negative effects as a result of participating in this study, you may contact Megan Hamshar, at (206)281-2378. If you have questions about your rights as a participant, contact the SPU Institutional Review Board Chair at (206)281-2201 or [IRB@spu.edu](mailto:IRB@spu.edu).



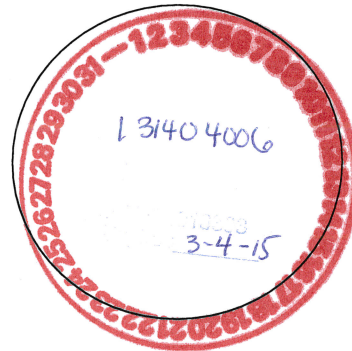
**CONSENT**

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in this research project and agree to participate in this study. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities.

I have read the above information and agree to participate in this study. I have received a copy of this form.

Participant's name (print) _____	Researcher's name (print) _____
Participant's signature _____	Researcher's signature _____
Date _____	Date _____

Copies to: Participant    Principal Investigator



## INSTRUCTIONS TO INVESTIGATORS:

### Preparing the Informed Consent Form

1. Use the format and headings given in the template. These headings are required by the Federal Office of Human Research Protections.
2. The SPU logo must be present.
3. After your IRB application is approved you will receive an IRB number and valid through date. **These must be added to your informed consent.**
4. Use language that is appropriate for an eighth grade reading level. You can test the reading level of your document in MS Word. See <http://www.ohsu.edu/research/rda/irb/docs/policies/readtips.pdf> for more suggestions for simplified writing.
5. Remember, you are speaking TO the participant. Make the language as clear and consistent as possible.
6. Do not use the word "I" except at the very end, since it can be interpreted as being coercive.

### Reviewing the Informed Consent Form with Participants

1. Prepare a copy for both the participant and the PI.
2. Read through the Informed Consent with the participant.
3. Make sure the participant initials any page besides the signature page
4. Give participants time to ask any questions before they sign the informed consent form.
5. Make sure that the participant as well as the researcher's signature is on both forms. Give the Participant his or her form before you begin the study.

### Informed Consent with minor

1. A parent or guardian must sign the informed consent for research with Children<sup>9</sup>
2. For Children over 7 to the age of 18 you need to prepare an informed assent form for their signature in addition to the adult informed consent. For Children under 14 consider a simplified version of your document. Children 14 & over can read and sign an assent document that is the same as their parents' consent.
3. You can receive verbal assent for children under 7. Provide a script for the verbal assent and a signature line for the researcher to acknowledge that they verbally reviewed the study and attained verbal assent from the minor.

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<sup>9</sup> Where the Federal government requires informed consent for research.