Perceptions of Serious Mental Illness in the Local Church

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ABSTRACT. The present study was undertaken to assess the perceptions encountered in the local church by individuals diagnosed with a mental disorder. Participants ($n = 85$) were self-identified, mentally ill Christians who responded to an anonymous online survey. Analysis of the data found that the church had dismissed the diagnoses of a significantly large number of the study participants (41.2%). Participants who were told that they did not have a mental illness were more likely to: 1) attend church more than once a week and to 2) describe their church as conservative, and/or 3) charismatic ("Spirit-filled"). Future efforts to bring the mental health and faith communities together must focus more on the specific conservative and charismatic doctrinal issues that presently limit such collaborations.

KEYWORDS. mental health, Charismatic, religious beliefs

Research has consistently shown that clergy, not psychologists or other mental health professionals, are the most common source of help sought in times of psychological distress (Chalfant et al., 1990; Clemens et al., 1978). Recognizing their position on the frontlines of intervention, psychologists have tended to view clergy as mental health "gatekeepers" (Gorsuch &

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Meylink, 1988; Meylink & Gorsuch, 1986). In this role clergy are thought to function as a referral source for psychologists, who then provide direct mental health services to the client (Benes, et al. 2000). Due in part to limited training in the recognition of serious mental illness (Larson, 1969; Mannon & Crawford, 1996; McMinn et al., 2005) and/or misguided beliefs about the origin of these disorders (Hartog & Gow, 2005; Trice & Bjorck, 2006) this process is likely to be inconsistent at best and, at worst, potentially harmful.

Previous research to assess attitudes and practices in the church towards mental illness has tended to survey individuals in full-time ministry (Lafuze et al., 2002; Trice & Bjorck, 2006) or lay Christians (Hartog & Gow, 2005). For example, Lafuze et al. (2002) found that most of 1,031 United Methodist clergy they surveyed had "an informed, scientifically based understanding of the causes of mental disorders and the importance of medications in effective treatment" (p. 901). Trice and Bjorck (2006) found in a survey of 230 Pentecostals training for full-time ministry that, when asked about the causes and cures of major depression, they accurately endorsed a number of potential non-spiritual causal factors (e.g., victimization, social relations, biological) but saw spiritual discipline and faith as the most effective treatment options. Similarly, Hartog and Gow (2005), in a study of 126 congregants from predominantly conservative Protestant denominations, found that participants who scored high on religious beliefs but low on counseling/psychology knowledge were more likely to attribute the causes and treatments for major depression and schizophrenia to religious factors. An additional finding of this study was that more than one-third of the participants endorsed a demonic etiology of major depression and schizophrenia.

Few studies to date have gathered data directly from individuals diagnosed with mental illness who have interacted with the church. In a recent survey of 293 Christians who approached their local church for assistance in response to a personal or family member's mental illness, Stanford (2007) found that 32.4% of these church members were told that they or their loved one did not really have a mental illness and that the cause of their problem was solely spiritual in nature (e.g., personal sin, demonic involvement). Analysis of these data by sex found that this finding was more likely with women than men. When asked how this interaction with the local church had affected their personal faith, 14.7% of the participants said that the experience had weakened their faith, whereas 12.6% said that they were no longer involved in the faith because of this incident. These results are troubling because they suggest that an initial negative

interaction with the local church may cause hurting and wounded individuals to isolate themselves from a potentially beneficial support system, the religious community (Corrigan et al., 2003; Lindgren & Coursey, 1995; Yangarber-Hicks, 2004).

The present descriptive study was undertaken to assess the attitudes and perceptions encountered in the local church by individuals diagnosed with a mental disorder. After reviewing the available literature, it was hypothesized that a significant percentage of the sample would report that their mental disorder was viewed as having only a spiritual basis (e.g., personal sin, demonic involvement) and that this finding would occur more often in: 1) women compared with men, and 2) conservative compared with liberal churches. It was further hypothesized that there would be no difference in the level of psychological distress or strength of religious faith in those whose mental disorder was dismissed and thought to be the result of spiritual factors compared with those whose psychiatric diagnosis was accepted by the church.

METHODS

Participants and Recruitment

Participants were 85 (68 women, 17 men) self-identified mentally ill Christians (71 Protestant, 14 Catholic) who responded to an anonymous online survey. Participants were recruited through online mental illness discussion groups using the following posting;

> My name is Matthew S. Stanford, Ph.D. and I am a professor of Psychology at Baylor University. I am presently gathering information on the interactions between Christians struggling with mental illness and their church. If you have sought help or counsel from your church in regards to a mental illness please go to [*URL*] and complete a brief, anonymous survey. Your feedback and involvement are greatly appreciated.

The online discussion groups used for recruitment included both faith-based ($n = 4$) and non-faith-based ($n = 25$) groups.

The mean age of the sample was 39.5 (SD 14.5). Most participants were Caucasian (87.1%), from the United States (89.4%), married (43.5%), and had attended at least some college (73.0%). A wide range

of psychiatric disorders were represented in the present sample: anxiety disorders, 87.1%; mood disorders, 85.9%; borderline personality disorder, 28.2%; eating disorders, 24.7%; schizophrenia and psychotic disorders, 15.3%; dissociative disorders, 15.3%; substance use disorders, 14.1%; and attention-deficit hyperactivity disorder, 8.2%. Of all participants, 64% were comorbid for at least two disorders. Present treatment with medication, psychotherapy/counseling or both was reported by 77.6% of participants. The remainder (22.4%) reported that they were not presently receiving treatment for their disorder.

Measures

All participants responded to a set of survey questions related to their mental illness and interactions with the church and completed the following two brief self-report instruments described in following text

Scale of Nonspecific Psychological Distress

The Scale of Nonspecific Psychological Distress (K6; Kessler et al. 2002) is a six-item scale developed to measure serious mental illness. Participants are asked to rate—using a 5-point Likert scale (0, none of the time; 1, a little of the time; 2, some of the time; 3, most of the time; and 4, all of the time)—how frequently they experienced symptoms of psychological distress during the past 30 days (e.g., "so sad that nothing could cheer you up"). A score of 13 or more on the K6 is reflective of serious psychological distress. The K6 has been shown to have a sensitivity of 0.36, a specificity of 0.96, and total classification accuracy for serious mental illness of 0.92.

Santa Clara Strength of Religious Faith Questionnaire

The Santa Clara Strength of Religious Faith Questionnaire (SCSORF; Plante & Boccaccini 1997). This 10-item self-report measure assesses the strength of a person's religious faith (e.g., "I look to my faith as a source of comfort"). Participants are asked to indicate their level of agreement or disagreement for each item using a 5-point Likert scale (1, strongly disagree; 2, disagree; 3, agree; and 4, strongly disagree). Scores on the SCSORF can range from 10 (low faith) to 40 (high faith). The questionnaire has been shown to have good internal consistency ($\alpha = 0.95$).

RESULTS

Church Contact and Support

Of the 85 study participants, 46% indicated that they had approached the church in relation to their mental illness only once. The remaining 54% interacted with the church in relation to their mental illness on multiple occasions. The most common person contacted at the church was the senior pastor/priest (55.3%) followed by a small group leader (34.1%), congregant/church member (32.9%), pastoral staff person (30.6%), lay counselor (11.8%), and elder/lay church leader (11.8%). When asked "What help or services were you hoping to get from the church in relation to your mental illness?" the most common answers were; guidance, counseling, support, and understanding. To the question "In your specific case, how much has the church been involved with this problem?" most (57.6%) of the participants responded not at all (18.8% a little, 17.6% somewhat, 5.9% a great deal). When asked "How much more would you have liked your church to be involved?" 36.5% responded a great deal more (17.6% somewhat more, 11.8% a little more). Satisfaction with the church's level of involvement was indicated by 22.4% of the participants, whereas 11.8% of the participants responded that they did not want the church more involved because they had made matters worse. A small majority (50.6%) of the participants felt that their family and friends (outside the church) were supportive of them in relation to their mental illness.

Attitudes Toward Mental Illness

All study participants answered the following questions related to attitudes they encountered at the church towards their mental illness:

1. Did anyone at your church ever suggest that you did not really have a mental illness even though a mental health professional had diagnosed you with one?—58.8%, no; 41.2%, yes.
2. Did anyone at your church ever suggest that you stop taking psychiatric medication for the treatment of your mental illness?—71.8%, no; 28.2%, yes.
3. Did anyone at your church ever suggest that your mental illness was the result of personal sin?—63.5%, no; 36.5%, yes.
4. Did anyone at your church ever suggest that your mental illness was the result of demonic involvement?—65.9%, no; 34.1%, yes.

TABLE 1. Percentage of Participants Reporting Negative Attitudes by Specific Church Staff and/or Congregants

	Negative Attitude Expressed			
Church Staff*	No Illness	Stop Medications	Personal Sin	Demon
Congregant / Church member	24.7%	20.0%	18.8%	21.2%
Senior pastor / Priest	18.8%	10.6%	21.2%	14.1%
Pastoral staff person	10.6%	3.5%	11.8%	8.2%
Lay counselor	4.7%	1.2%	3.5%	2.4%
Small group leader	4.7%	1.2%	3.5%	3.5%
Elder / Lay church leader	3.5%	4.7%	5.9%	5.9%

*Participants may have reported more than one individual that expressed a given negative attitude.

Participants also identified who had expressed each of these negative attitudes (Table 1). In the examples just given, it was most commonly a congregant/church member or senior pastor/priest that expressed this attitude towards the participant.

Potential Contributing Factors

Analyses were conducted to determine what factors contributed to the dismissal of a mental disorder diagnosis (question 1 noted previously) in the present sample. No association was found for age ($F(1,83) = 1.44$, $p = 0.23$), education (χ^2 (4) $= 4.21$, $p = 0.37$), or gender ($\chi^2(1) = 0.30$, $p = 0.58$). Analysis of variance showed no difference in level of psychological distress ($F(1,83) = 0.807$, $p = 0.37$) or strength of religious faith ($F(1,83) = 0.031$, $p = 0.86$) between individuals told that they did not have a mental illness and those whose illness was not discounted (Table 2).

Chi-square analyses (Table 2) did find that individuals who were told that they did not have a mental illness were more likely to describe their church as conservative in relation to doctrinal issues and the interpretation of scripture ($\chi^2(4) = 9.49$, $p = 0.05$) and more likely to describe their church as charismatic or Spirit-filled ($\chi^2(1) = 5.63$, $p = 0.02$). Individuals whose mental illness was denied also attend church significantly more often than those whose illness was not denied ($\chi^2(2) = 6.19$, $p = 0.04$). When the church denied the existence of an individual's mental illness, they were then more likely to be told that the cause of their problems was personal sin ($\chi^2(1) = 14.22$, $p < 0.01$) or demonic involvement ($\chi^2(1) = 21.86$,

TABLE 2. Comparison of Groups on Factors Contributing to the Dismissal of Diagnoses

	Diagnosis		
Measure	Dismissed $n = 35$	Not Dismissed $n = 50$	p
Age	36.6 (15.2)	40.5 (14.7)	0.23
K6	19.1 (6.2)	17.9 (6.5)	0.37
SCSORF	29.8 (8.2)	30.2 (8.7)	0.86
Gender			0.58
Male	17.1%	22.0%	
Female	82.9%	78.0%	
Education			0.37
Less than HS	8.6%	12.0%	
HS graduate/GED	14.3%	18.0%	
Some college	62.9%	42.0%	
College graduate	8.6%	12.0%	
Graduate or professional degree	5.7%	16.0%	
Doctrine			*0.05*
Conservative	57.1%	26.0%	
Somewhat conservative	20.0%	38.0%	
Moderate	8.6%	20.0%	
Somewhat liberal	5.7%	4.0%	
Liberal	8.6%	12.0%	
Charismatic (Spirit-filled)			*0.02*
Yes	60.0%	34.0%	
No	40.0%	66.0%	
Attendance			*0.04*
More than once/week	37.1%	14.0%	
Once a week	22.9%	34.0%	
Less than once/week	40.0%	52.0%	
Personal sin			*< 0.01*
Yes	60.0%	20.0%	
No	40.0%	80.0%	
Demonic involvement			*< 0.01*
Yes	62.9%	14.0%	
No	37.1%	86.0%	
Stop medication			*< 0.01*
Yes	57.1%	8.0%	
No	42.9%	92.0%	

HS, high school; GED, general equivalency diploma; K6,Scale of Nonspecific Psychological Distress; SCSORF, Santa Clara Strength of Religious Faith Questionnaire.

$p < 0.01$) and that they should stop taking medication for their disorder ($\chi^2(1) = 24.54$, $p < 0.01$).

DISCUSSION

The results of the present study suggest that individuals in the local church are denying or dismissing a high percentage (41.2%) of mental disorder diagnoses. In addition, those individuals whose mental illness is dismissed are being told that their psychological and emotional distress results solely from spiritual factors and that medication is not necessary and should not be taken as treatment. Sadly, 57.6% of the study participants indicated that the church was "not at all" involved during their time of crisis.

Analysis of the K6 questionnaire showed no difference in the level of psychological distress for those individuals whose diagnosis was dismissed. In fact, 81.2% ($n = 69$) of the total sample met the K6 criteria for serious psychological distress (85.7% of those whose diagnosis was dismissed and 78.0% of those whose diagnosis was not dismissed) and the frequency of Axis I psychopathology did not differ between groups. So the dismissal of diagnoses in this sample is likely not the result of individuals with minor mood state changes or misdiagnoses seeking assistance from the church.

Dismissing the diagnosis of a mental disorder and attributing the symptoms to spiritual factors such as personal sin or the demonic may call into question a person's faith. Yet, no significant difference was found in strength of religious faith between the groups. Individuals whose diagnoses were dismissed actually attended church significantly more often than those whose disorders were not dismissed.

Consistent with the original hypotheses, dismissal of a diagnosis was more common in churches described as conservative on doctrinal issues and the interpretation of scripture. This finding is in keeping with previous research that has shown conservative clergy are significantly less likely to refer individuals to mental health professionals than liberal clergy (Mannon & Crawford 1996). Dismissal of diagnoses was also found to occur more frequently in charismatic (Spirit-filled) churches. Charismatics tend to hold traditional Evangelical beliefs but emphasize the working of the Holy Spirit in the life of the believer (e.g., miracles, healing, speaking in tongues). These results are consistent with previous studies that have shown conservative Christians (including Charismatics) are more likely to

attribute the causes of mental illness to spiritual factors and believe that faith is the most effective treatment option (Hartog & Gow 2005; Trice & Bjorck 2006). Although a past study (Stanford 2007) found that the mental disorder diagnoses of women were more frequently dismissed than those of men, the present study failed to replicate this finding. This finding may have been due to the low percentage of men in the present sample (20%).

The present study is limited by a small sample and thus the results should be viewed as preliminary and interpreted with caution. An additional limitation of this study is that the results are based on a non-random convenience sample composed solely of internet users. This sampling method resulted in a group of participants that was biased for females and Protestants. While a better sampling method is needed in future studies, the present results are consistent with previous research as discussed above.

An affirming, supportive religious community can play a vital role not only in recovery from serious mental illness but also in prevention (White et al. 2003). While most Christian clergy and churches are sympathetic to individuals with mental disorders, it appears that some conservative and charismatic congregations are not. While resources for psychologist-clergy collaborations have been developed (Benes et al. 2000; McMinn et al. 2003), the present results suggest that future efforts must focus more on the specific conservative and charismatic doctrinal issues that presently limit such collaborations if the mental health and faith communities are to be brought together.

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