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# A New Church Model: Inviting and Including People With or Affected by Mental Health Conditions

by

Robyn Kay Bradley Bishop

Because one in five people live with a mental illness and knowing that myself, as well as others, have felt the shame and fear associated with a mental health condition, I began this project to broaden my understanding of mental illness and the Church's response. In an exploration of local churches and community organizations, which serve people with mental illness or mental disorders in the downtown Orlando area, I designed and administered surveys, questionnaires, and interviews. The purpose of this project was to explore practices of church models and community organizations that faithfully invite and include people with or affected by mental illness, in order to develop a new church model for downtown Orlando, Florida. The following three research questions were used to create a solution to the problem for this project: 1) What are the unique dimensions of ministry with people who have been affected by mental illness? 2) What is missing in downtown Orlando that would help people affected by mental illness? 3) What are some best practices for inviting and including people affected by mental illness in the context of a local church?

There are five major findings for this research project. First, people with or affected by mental health conditions need to have belonging in a community, not just inclusion, so they will not feel relegated to life in the margins. Second, because the scriptures tell God's people to be a voice for the voiceless, the church has a responsibility to advocate for people living with or affected by mental health conditions through

education and being educated. Third, involvement in the life of a church should include discipleship and leadership even in the midst of brokenness or weakness of physical, mental or emotional illness. Fourth, there should be a blending of church models in the development of a new church model for people with or affected by mental health conditions. Fifth, the practice of healing would be useful when developing ministry for people living with or affected by mental health conditions.

DISSERTATION APPROVAL

This is to certify that the dissertation entitled

**A New Church Model: Inviting and Including People**

**With or Affected by Mental Health Conditions**

presented by

Robyn Kay Bradley Bishop

has been accepted towards fulfillment

of the requirements for the

DOCTOR OF MINISTRY degree at

Asbury Theological Seminary

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| Dissertation Coach | Date |
| ______________________________ | ______________________ |
| Representative, Doctor of Ministry Program | Date |
| ______________________________ | ______________________ |
| Dean of the Beeson Center | Date |

**A New Church Model: Inviting and Including People**

**With or Affected by Mental Health Conditions**

A Dissertation

Presented to the Faculty of

Asbury Theological Seminary

In Partial Fulfillment

Of the Requirements for the Degree

Doctor of Ministry

by

Robyn Kay Bradley Bishop

May 2018

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**TABLE OF CONTENTS**

Page

LIST OF TABLES……………………………………………………………………vii

AKNOWLEDGEMENTS…………………………………………………………..ix

CHAPTER 1 NATURE OF THE PROJECT ........................................................................1

Overview of the Chapter…………………………………………………………1

Autobiographical Introduction……………………………………………………1

Statement of the Problem…………………………………………………………4

Purpose of the Project……………………………………………………………..6

Research Questions…………………………………………………………….…6

.

Research Question #1……………………………………………………..6

Research Question #2……………………………………………………..6

Research Question #3……………………………………………………..6

Rationale for the Project…………………………………………………………..6

Definition of Key Terms…………………………………………………………11

Delimitations……………………………………………………………………..13

Review of Relevant Literature…………………………………………………...14

Research Methodology…………………………………………………………..15

Type of Research…………………………………………………...15

Participants………………………………………………………………16

Data Collection…………………………………………………..…....17

Data Analysis……………………………………………………………18

Generalizability…………………………………………………………..18

Project Overview……………………………………………………………..19

CHAPTER 2 LITERATURE REVIEW FOR THE PROJECT…………………………19

Overview of the Chapter………………………………………………........19

Biblical Foundations…………………………………………………………..21

What does the Bible say about Church?…………………………….…….21

What does the Bible say about Mental Illness?..........................................25

Theological Foundations………………………………………………………30

Can Claiming an Identity in Christ Impact the Issue of Mental Illness?….......30

Why Does God Allow Mental Illness? …………………..…………………32

Is Mental Illness Related to Sin?..................................................................33

Why Should We Start Churches?.................................................................35

Why Have a Church Including People Affected by Mental Illness?…………36

Luke 4:18-Good News to the Poor……………………….…………..37

Luke 4:18-Release to the Captives……….…………….....…………39

Luke 4:18-Recovery of Sight for the Blind……………………………..40

Luke 4:18-Let the Oppressed Go Free…..………..……..……....……..42

Research Themes…………………………………………...……………45

Church Planting……………………………………………..….……46

Multiplication Versus Planting…………………………….……...…48

Church Models……………………..…………………..……....……......50

The Institutional Model……………………..………………………..52

Missional Model……………………………………………………..53

The Recovery Minded Model………………………………………55

Fresh Expressions……………………………………………………59
Home Church or Table Fellowship Model……………………………60
Church Practices Including People Affected by Mental Illness………………63
What is Mental Illness?..........................................................................65
How is Culture Responding?.................................................................69
How is the Church Responding?...........................................................74
Research Design Literature.....................................................................77
Summary of Literature…………………………………………………78
CHAPTER 3 RESEARCH METHODOLOGY FOR THE PROJECT……………………82
Overview of the Chapter………………………………………………82
Nature and Purpose of the Project………………………………………82
Research Questions……………………………………………………83
Research Question #1…………………………………………………83
Research Question #2…………………………………………………83
Research Question #3…………………………………………………84
Ministry Context for Observing the Phenomenon…………………………84
Participants to Be Sampled About the Phenomenon ……………………86
Criteria for Selection …………………………………………………86
Description of Participants……………………………………………86
Ethical Considerations …………………………………………………87
Instrumentation…………………………………………………………88
Expert Review……………………………………………………………88
Reliability & Validity of Project Design…………………………………88

Data Collection……………………………………………………………………..89

Data Analysis………………………………………………………………………90

CHAPTER 4 EVIDENCE FOR THE PROJECT……………………………………..92

Overview of the Chapter….…………………………………..……………….…92

Participants….……………………………………………………..………..92

Research Question #1: Description of Evidence……………………..................95

Community Organization Leader Survey Results
Community Organization Leader Questionnaire Results
Community Organization Leader Interview Results
Church Pastor/Leader Survey Results
Church Pastor/Leader Questionnaire Results
Church Pastor/Leader Interview Results

Research Question #2: Description of Evidence………………………………103

Community Organization Leader Survey Results
Community Organization Leader Questionnaire Results
Community Organization Leader Interview Results
Church Pastor/Leader Survey Results
Church Pastor/Leader Questionnaire Results
Church Pastor/Leader Interview Results

Research Question #3: Description of Evidence………………………………111

Community Organization Leader Survey Results
Community Organization Leader Questionnaire Results
Community Organization Leader Interview Results
Church Pastor/Leader Survey Results
Church Pastor/Leader Questionnaire Results
Church Pastor/Leader Interview Results

Summary of Major Findings.……………………………………………...115

CHAPTER 5 LEARNING REPORT FOR THE PROJECT…………………………...119

Overview of the Chapter.…………………………………………………….119

Major Findings…………………………………………………………….119

Embracing, Not Just Inclusion…………………………..…………119

The Church's Responsibility for Social Justice……………………….……..129

Discipleship and Leadership in the Midst of Weakness……...……..…...139

Blending Church Models……...…………………………………………144

The Practice of Healing…………………………………………….….…150

Ministry Implications of the Findings…………………………………………156

Limitations of the Study……………………………………………...…………159

Unexpected Observations………………………………………………………160

Recommendations……………………………………………………...………160

Postscript…………………………………………………………………………162

APPENDICES

A. Intro Letter and Consent Form for Community Organization Leader…...…165

B. Intro Letter and Consent Letter for Church Pastor/Leader………..……...167

C. RBB Community Organization Leader Survey/Questionnaire……………..169

D. RBB Church Pastor/Leader Survey/Questionnaire…………….…………172

E. List of Community Organization Leaders in Orlando………….……………175

F. List of Church Pastors/Leaders in Orlando…………………..……………...177

WORKS CITED…………………………………………………………….........179

WORKS CONSULTED…………………………………………………….……….185

# LIST OF TABLES

Page

Table 4.1 Responses of the Twenty-Five Community Organization Leaders…………92

Table 4.2 Demographics of the Four Community Organization Leaders Participants...93

Table 4.3 Responses of the Twenty-Seven Church Pastors/Leaders…………………..94

Table 4.4 Demographics of the Eight Community Organization Leaders Participants..94

Table 4.5 Responses to Survey Statement #2…………………………………………..95

Table 4.6 Responses to Survey Statement #4…………………………………………..95

Table 4.7 Responses of Community Organization Leader Question #4 Results...……96

Table 4.8 Responses of Church Pastor/Leaders to Survey Statement #3………………99

Table 4.9 Responses of Church Pastor/Leaders to Survey Statement #4……………..100

Table 4.10 Responses of Church Pastor/Leaders to Question #5 Results……………..100

Table 4.11 Response to Community Organization Leader Survey Statement #3……..103

Table 4.12 Response to Community Organization Leader Survey Statement #5……..103

Table 4.13 Response to Community Organization Leader Survey Statement #6……..103

Table 4.14 Responses of Community Organization Leader Question #5 Results…….104

Table 4.15 Response to Church Pastor/Leader Survey Statement #5…………………106

Table 4.16 Response to Church Pastor/Leader Survey Statement #6…………………106

Table 4.17 Response to Church Pastor/Leader Question #7…………………………..107

Table 4.18 Response to Church Pastor/Leader Survey Statement #1……………..….110

Table 4.19 Response to Church Pastor/Leader Survey Statement #2…………………110

Table 4.20 Response to Church Pastor/Leader Question #2…………………………..111

Table 4.21 Response to Church Pastor/Leader Question #6…………………………..114

## ACKNOWLEDGEMENTS

Jesus, thank you! I love you with all that I am! Thank you for healing my inmost being, giving color to my world and filling me with your Spirit of love! Thank you for trusting me to share your love with your people, for the sound mind to bring this research project to completion and to life in the fruit of these labors!

Thank you for being my best friend, Stew! You have shown me what the unconditional love of Jesus looks like. I love you with all my heart! I am grateful that we encourage each other to grow and to live into the gifts God gives us! You are a brilliant truth purveyor, a faithful follower of Jesus, incredible husband and a loving father!

Thank you to my kids, including the two that have married into our family: Kelsey, Casey, Cameron, Brandon and Phil! Thank you for your support and your love! I absolutely love being your mom and mom in law! It is the greatest privilege that God has given me! Thank you to my adorable granddaughters, Emma and Ellie, who have shared this journey with me. I look forward to more fun together painting and creating, visiting art museums, parks, coffee shops, and bookstores along with more conversations about Jesus! We have so many adventures ahead!

Thank you to my mom and dad, Janie and Ray, for loving me, praying for me and believing in me! I love you! Thank you, Mom and Dad Bishop, Betty and Alex: you have loved me as your own! I love you! Olivia, your fortitude and resilience are amazing; thank you for your patience when I couldn't hang out, because I was working on this project! Thank you, Becca, for always supporting me and always loving me!

Thank you, Marc Donaldson for being a steadfast example of Jesus who inspires and encourages me! Under your leadership I accepted the call to be a Pastor and through your mentoring I have made it through this DMin program!

Thank you, Hometeam, Pamela, David, Ian, Sarah, Leanne, Marcus and Marc, for sharing this life, for all the dance parties, for your prayers and for your love!

Thank you to The Distribution Center board! I am especially thankful to you, Rich Stevenson, and the Malachi Network, for your sponsorship of me in this Doctor of Ministry program! I am also grateful for the prayers and mentoring of you and Tania as we transitioned from Texas to Florida and planted this new faith community (TDC)!

Thank you to The Distribution Center, who has been willing to share this journey! It has been a privilege to gather around the table, sharing the Word and the experience of the Spirit's distribution of healing and hope! Susan, you were the first to say, YES! You bring hope to this intersection of Washington Street and Celia Lane.

Thank you, Dr. Collier, for being my coach through writing this dissertation and for your guidance as we learned about church planting in Mississippi! Thank you, Dr. McPhee, for your guidance and leading as we traveled through what it means to be a church planter, especially in Thailand! Thank you, Dr. Marmon, for the sweet conversations over meals, for helping bring order to my confusion over this dissertation and for a new friendship! Thank you, Dr. Milton Lowe and Dr. Verna Lowe, Lacey, and Ashley for your guidance in navigating this program and project. Thank you, Dr. Tumblin, for inviting me to be a part of the Doctor of Ministry program and believing in the vision God has granted! Thank you to those who offered me the resources of the Beeson Scholarship. This has been a very sweet three years!

Thank you to all of my Church Planting Cohort! You have enriched my life with our experiences and with your prayers! I am particularly grateful to you, Carolyn, for our talks while rooming together, and to you, Victor, who has been such an encourager, and to you, Sam, your family and our time together in Nepal!

Thank you to all of those who helped with the research for this project from those who gave me feedback on the design of the research tools, to the leaders and pastors of the churches and community organizations who participated in the research, to those with whom I had conversations about mental illness, the Church or church planting. I am particularly grateful to Amy Simpson, David Mandani, Melissa Mayer and John Tardonia for the conversations we had and your vulnerability in sharing your stories.

And finally, I acknowledge the people who live with or have been impacted by mental health conditions. There are a lot of us. May we never give up advocating and supporting each other. May we seek dignity in the identity we have as image bearers of God, not diminished by our mental health conditions. May we find healing in community brought together by distribution of the Spirit's love, healing and hope.

# CHAPTER 1

## Overview of the Chapter

The purpose of this project was to explore the practices of church models and community organizations that faithfully invite and include people with or affected by mental health conditions in order to develop a new model for downtown Orlando, Florida. Many churches address ministry needs for people with addictions or who offer counseling services for those in crisis. However, this project was concerned with the effectiveness as well as the gaps of ministry to people affected by mental health conditions in current church models. This chapter will expound on the ideas as to why the author of this project thinks there is good reason to pursue the experiment as well as offer the parameters for how this project will unfold after the project is completed. There will be discussion on the biblical, theological, and ecclesiological reasons to have a church model with such intentions. In the last section of this chapter, the type of methodology and the time line for using the methods chosen for this project will be laid out. Because this is a broken world, there are a variety of ways for people to experience loss and pain. It is the hope of the author of this project that a new church model could be developed to embrace people affected by mental illness with grace and love.

### Autobiographical Introduction

In 2002, I answered the call to ordained ministry in the United Methodist Church (UMC). I then started seminary at Perkins Theological Seminary in 2003. I had participated in a variety of roles such as: graphic designer, art teacher, mom and church volunteer. In 2008 as I entered into my last year of seminary, the Holy Spirit began to stir in me a desire to pray about starting a new church. After talking to UMC leadership, I

was asked to seek training and found myself on the District Board that set strategies for where and how to start new churches. I was also appointed to serve as an Associate Pastor under the leadership of a man who had started Good Shepherd UMC fifteen years prior.

Four years after I had arrived at Good Shepherd, I was asked to share my story at a women's retreat. I was convicted that this would be the time to publicly share that God had resurrected my life from bondage of depression, anxiety, and an eating disorder. I also shared about the heart wrenching days of seeing the effects of addiction and mental illness when my brother was going through a divorce and trying to care for his four kids. At the end of this retreat, we were to close with a short communion service. I offered to pray with those who might be struggling with addiction or mental illness or for their loved ones. At least fifteen to twenty people came forward to pray. After this experience, the number of people who admitted struggles associated with mental illness multiplied so much so that I began to consider this was an answer to the prayer about who I was called to reach. God was showing me to use my greatest weakness and pain for his purpose and glory.

From 2009 to 2015 the lack of knowledge about mental illness in our culture became more apparent to me. Through several conversations with the Senior Pastor of my church, my District Superintendent and our conference Director of New Church Starts, I began to put a plan together to develop a faith community within our church to reach people with mental health issues. While doing this I discovered two other churches reaching the demographic that I wanted to reach. It was suggested that I visit Chapelwood UMC's faith community, *Mercy Street,* in Houston, to learn how their

community dealt with addiction and mental illness. In 2012, while participating in a leadership development group, I heard the testimony of Pastor Jamey Lee from *Jacob's Well* in Memphis, Tennessee and found myself enthralled by the concept of this church being developed as a recovery community for people with addiction. Using the basic twelve-step program of Alcoholics Anonymous, Pastor Lee created a twelve step Christian recovery model for his church. In this season of praying, researching and learning, the Lord actually gave me a vision for a warehouse with a two-tiered fountain, a house and a coffee shop, which included space to be used to offer mental health resources and development of creative arts for people with mental illness. Affirmation to pursue this vision came as I talked about this vision with my family and learned that my oldest daughter said she had gone to her church in Orlando to talk about creating a resource-counseling center.

After many months of God's nudging in 2014, I accepted God's call to fast from food; I consumed liquids for forty days. During my fast, my mentor, Marc Donaldson introduced me to Tom Tumblin, who invited to apply for a Doctor of Ministry in church planting at Asbury Theological Seminary. The day after I broke my fast, I received a call from a journalist with the New York Times asking me to talk about the connection between spirituality and mental illness. The reporter had received my name from Joe Padilla with Mental Health Grace Alliance, who had spoken at a conference I had been a part of organizing at our church the year before. Could this all be coincidence or a God incidence? In December of 2014, I applied to Asbury, and sought counsel from my Senior Pastor, District Superintendent, the Bishop of the Texas Conference, Rich Stevenson of the Malachi Network, Marc Donaldson, family and friends. In July of

2015, I left my appointment as Associate Pastor in Cypress, Texas in response to the leading of the Holy Spirit and moved to Orlando, Florida. Both of my daughters, who have been degrees in social work shared the fervor to create a church with a focus on reaching people affected by mental illness.

The quest to start a new church is in response to a burden on my heart to create a faith community that will share the faith, hope and love of Jesus Christ with those who feel invisible including those with mental illness. The people I hope to reach are those who feel inhibited to take off their masks in the traditional Church, because they have felt rejection or judgment whether real or perceived due to their struggle with a mental illness or ongoing mental health issues.

**Statement of the Problem**

This world is full of people who are broken hearted over loss of relationships, loss of life, loss of dreams, or loss of hope. There are many who have been victims of sexual abuse or poor choices by generations before them. Many suffer from mental illness, which includes a variety of diagnoses and levels of severity, such as: bipolar disorder, depression, post-traumatic stress disorder, an eating disorder or schizophrenia. It is said that "one in five people live with mental illness" in a given year, thus, all people are impacted in some way (www.nami.org). The first place people go when trying to cope with trauma in their life is often the church. However, there are still many people who think they are unworthy to go the church to ask for help. Many people may be afraid to enter a traditional church because they feel like they need to wear a mask to cover their struggle. The author of this paper has spoken with many people prior to the beginning of this project who have said they are afraid to tell others of their struggles with mental

illness for fear of being judged or rejected even by those who call themselves Christians. Whether intentional or subconsciously judgmental words like “crazy,” “loony,” or “stupid” are tossed about in Christian circles to describe people that have mental illness. These are words used daily to describe situations or people, which a person does not understand. This perception has infiltrated modern culture inside and outside of churches. When someone uses these types of words, they are putting a wall between people who are mentally healthy and those who are struggling. It seems probable that a group of people could be separated from the Church because they feel unwanted or unworthy. A new church model could create reconciliation in communities by being intentional in treating people with mental illness not as a “mission project” but as a neighbor who needs to be heard, to be shown grace and to be included in day-to-day living. In Orlando there are many churches with counseling services, but what might need to be done differently to be more inclusive to those with mental illness? What might be missing in how the church responds to people with mental illness?

This project will reveal practices for how a church can develop community to empower people who live with mental illness or who have loved ones who do so they can receive the distribution of the Holy Spirit and have a fruitful, meaningful life in a relationship with Jesus. Mental illness and how the church can respond to those impacted throughout the city of Orlando will be discussed. This project will create insights for how the church should be connected as a community to one another even with mental illness and to our triune God.

## Purpose of the Project

The purpose of this project was to explore the practices of church models and community organizations that faithfully invite and include people with or affected by mental health conditions in order to develop a new model for downtown Orlando, Florida.

## Research Questions

The following overarching research questions guided the direction of this project. In order to answer these questions, the following topics were researched: mental illness or mental health conditions, church planting, and church practices.

### Research Question #1

What are the unique dimensions of ministry with people who have been affected by mental illness?

### Research Question #2

What is missing in downtown Orlando that would help people affected by mental illness?

### Research Question #3

What are some best practices for inviting and including people affected by mental illness in the context of a local church?

## Rationale for the Project

There may be many reasons to pursue this transformation project; three will be three introduced here. The first reason is that there is an assumption that the Church could be doing more to provide inclusiveness for people affected by mental illness within the life of their community. Secondly, this project should be pursued because there are a lot

of people who do not understand mental illness. And thirdly, this project should be done because there are people who live in shame of their illness rather than embracing their identity as a person created with God's love and grace.

Everyone needs community including people who struggle with mental illness. God is a God of otherness who created humans in his image with a need for a relationship with God and other human beings. In the core of each human lies the need for significance, which people can glean from a variety of external places, but the church has the unique opportunity to create community that invites people to know they matter and have value in the midst of society rather than being relegated to life in the shadows. A person with a mental health condition does not usually need to be quarantined. People need people. And really, people need to reach outside of themselves to serve one another. People can find significance in their jobs; in their responsibilities within community life outside of the church or in the role they have in their families or friendships. However, this project will consider how a person with mental illness may feel excluded from the mainstream of a faith community or in roles of leadership within a church. With advancement in various sciences including psychology, one may assume that Americans would have a greater ability to live authentically with people who mental illness diagnoses. Yet society seems to be still be living in fear and misunderstanding. On the websites of both National Alliance on Mental Illness (NAMI) and Mental Health Grace Alliance (MHGA) it is stated that one in five people will struggle with mental illness in a given year within the United States, about sixty-two million people (www.nami.org). Some church campuses have licensed counselors to aid suffering persons and some church campuses have support groups associated with organizations like Alcoholic

Anonymous (AA) or National Alliance on Mental Illness (NAMI). According to Joe Padilla of Mental Health Grace Alliance, their organization offers support and resources for people with mental health conditions. They provide training for support groups so people can experience a meaningful life. Padilla suggests that community is important in the healing process (www.mhga.org Padilla). What if communities were formed that empowered people affected by mental illness to not just have a place to ask for help but a church that encompasses being on a journey together in pursuit of knowing and following the God who created them?

Second, both within and beyond the local church, there are misconceptions surrounding the topic of mental illness. This project will specifically seek to address the stigma associated within American society. Historically churches have addressed needs in their communities by doing things like starting hospitals, creating food pantries, women shelter's, or even counseling centers as they sought to represent Christ in the world. The Church, however, has struggled with how to address mental illness beyond "fixing" them. In some Christian denominations, mental illness has been associated with demonic spirits or sinful behavior. This association has been communicated to society at large with the implicit message that people with mental illness are bad and therefore, not welcome into the Church. Quite often people struggling with mental illness are told they should pray more, join a Bible Study, read their Bible more or go to a counselor, but there is a lack of understanding about what mental illness is or is not. There are several places in scripture like Mark 1:32, where Jesus is said to have healed those who were demon possessed yet there is no mention of healing mental illness. There were no professional tests in the first century to assess a person's mental state. In the last one hundred years the

sciences have revealed a great deal about the brain and how it works. For example, over the centuries symptoms of the illness schizophrenia were noted, but a psychiatrist didn't give the illness a name until 1911. In 2015, NAMI estimated that about two and a half million people lived with a diagnosis of schizophrenia; some can live on their own and some have such severe cases that they need hospitalization (www.nami.org). The Apostle Paul wrote in his letter that followers of Jesus Christ should renew their minds to be like Jesus, but how does someone with an illness like schizophrenia attain such focus and renewal (Eph. 4:23)? Could it be that American society lives in fear of the mention of mental illness so they avoid discussing it? Could the Church help American society deal with the fear and shame that has developed by starting a new church model that intentionally embraces mental illness and mental health conditions? There are so many mental illnesses with such a broad span of stages; some are chronic and some acute. Some people who are diagnosed with depression will need medication every day for the rest of their lives, and some have such a mild case that they can seek counseling over a period of time. Then they may be fine with no medication needed at all. There should be more empathy, compassion and grace for those struggling with mental illnesses like, depression, bipolar disorder, eating or personality disorders, anxiety, obsessive/compulsive disorder or ADD/ADHD. In the survey results reported by Lifeway Research, the panel limited their research to questions about three acute mental diagnosis: depression, bi-polar and schizophrenia (*"Study of Acute Mental Illness and Christian Faith*" Lifeway Research 3). Yet as listed previously the author of this paper would like a consideration for a much broader scope. There is a stigma associated with mental illness in the modern day American society so a person may tell a professional counselor or

pastor about their struggle but will often hide their struggles from others. It may be that the Church could be a part of educating people about mental health and illness and thus, could be an advocate to eliminate stigma and misconceptions.

Third, God wants people to know that their identity is not in what they have done or not done but in him. God created humanity in his image and even though humanity has fallen under the curse of sin, God shows grace and a desire for each one of his created to have an abundant life so that no one feels insignificant or invisible. Identity is not wrapped up in a person's physical, mental or emotional state. The New York Times stated that the suicide rates "rose steadily in nearly every state from 1999 to 2016, increasing 25 percent nationally, the Centers for Disease Control and Prevention reported In 2016, there were more than twice as many suicides as homicides" ("*Defying Prevention Efforts, Suicide Rates Are Climbing Across the Nation"* Carey). Suicide is the third leading cause of death among young adults between the ages of eighteen and twenty-five years of age (www.nami.org). The numbers are alarming and include people who already have claimed to follow Jesus. It is important to note that being a follower of Jesus does not exclude someone from having a mental illness. It is a challenge for the church to determine how to accept and show grace when someone is struggling with "following" or claiming a "mind in Christ" (Phil. 2:2). The scriptures reveal the steadfast love and grace of God for his created. How then can the church show love and grace so people with mental illness will feel valued and significant even as imperfect people struggling to claim the mind of Christ? Many churches do a great job of adding ministries that reach out to people with mental illness, but many call people with mental illness, EGR's, meaning people where *extra grace is required*, as if they are a burden rather than

someone of value or love. Could a new church model be developed in such a way that people involved could claim that their identity is in being a child of God and not as wrapped up in what they can or cannot do?

**Definition of Key Terms**

For this ministry transformation project there are several terms that will need to be clarified: *Church and church, church model, church practices, mental illness and following Jesus.* To define these terms will help in clarifying the answers to the questions being asked. There may be several definitions that could be applied to these words, but how these terms will be used for this project will be shown here.

**Church**

**Church** means the whole, universal church of the world; it will not mean a particular denomination or representation although there is general understanding here that the gathering consists of Christians or followers of Jesus Christ who believe in the One Trinitarian God (Father, Son, Holy Spirit). The **Church** could be any gathering or collective of people, small or large, that someone has entered and become a member in some way like with baptism or covenantal vows. Within the Bible, the book of Acts has several stories of how the **Church** first gathered just after Jesus Christ was resurrected and ascended. In addition to this book, the apostle Paul wrote several letters that are included in the Bible with guidelines for what the Church should do in various situations, particularly in worship. In the twenty first century, there are at least a dozen descriptions of what the **Church** looks like beyond the definition of "a gathering of people." This paper acknowledges there are various forms of gatherings in the name of Jesus Christ. Some have very organized systems and some are more organic with very little structure.

All gatherings are a part of one body in Christ. The **church** will indicate a smaller collective of people in specific local settings.

**Church Model**

**Church model** refers to the various types of gatherings or expressions for a local church. There are **house church models** that focus more on gathering as a family sharing scripture and a meal in a home setting. There is a **missional model** that is intentional about having a missionary mindset so that sharing day-to-day life in a neighborhood setting is as important as gathering for worship. There is the **institutional model** that consists of more traditional governing and gathering for worship and programs. As addictions and enabling of addictive behaviors has become understood, a new expression has developed called the **recovery model.**

**Mental Illness**

**Mental illness** refers to a broad spectrum of diagnosis. Some are acute. Some are chronic. Some have minor conditions and others more severe. The goal of this paper is to shed light on the scope of what is to be included within the possibilities for a **mental illness** diagnosis and how to live an abundant life without shame or guilt. This paper is not meant to produce any medical documentation but to be a vehicle to articulate opportunity for a new way of being the Church so people will not feel the need to wear a mask in a community that proclaims the power of Jesus Christ. Issues like insurance or medical coverage or policies regarding mental health will not be addressed with any detail in this project though history may be presented as it relates to how the stigma of **mental illness** has developed. **Mental illness** is not fully determined by genetics or the environment. Its severity can vary just like physical illnesses can vary. Some cases can be

treated through out patient counseling and some need hospitalization. Some illnesses can affect someone for only a season of their life and some illnesses are chronic, constantly needing to be managed. **Mental health** is a term used when discussing the physiological, emotional or social, well-being of a person. Some people do not like to use the term **mental illness**, so other terminology will be explored.

**Follow Jesus**

The goal of a new church model is not just to identify people affected by mental health conditions; the Church has a mission to introduce people to know Jesus and to **follow Jesus**. The ability to **follow Jesus** comes by the power of the Holy Spirit who is given to a person by faith so they can believe and accept what God has given them through the crucifixion and resurrection of Jesus. The Holy Spirit is not given like a present under a tree but is an unseen gift received within a person. It is recognized that there are various stages of growth for a person and so it is the hope of this author to suggest a church model that will seek to help people through the various aspects of life whether it be physical, spiritual, emotional, relational, or mental.

## Delimitations

In this transformation ministry project, the information gleaned from a variety of sources was used to develop a survey and questionnaire which was used for follow up interviews with participants derived from a list of churches and a list of community organizations who have some sort of mental health ministry. The lists were discovered through a Google search for churches and community organizations within downtown Orlando. No children were interviewed; only adult pastors or adult leaders were contacted. The study was designed so that if one of these pastors or leaders had a mental

illness and could, they could have withdrawn from this project at any time. There was no intent to interview people who were hospitalized or struggling with a severe mental illness. The number of surveys or interviews administered was determined by the choice of the participants from the lists created through the Internet search.

## Review of Relevant Literature

In addition to inquiries made with churches, who have ministry with those affected by mental illness, there was research done online in search of different models for starting churches. The goal of this paper was not to develop a church model that "gets butts in seats" but to seek a creative model of church focused on transformation by the Holy Spirit, inclusion of the specified group and hope for life given through reconciliation with Jesus and one another. Relevant literature about missional churches, recovery-minded churches or ministries, community focused church models, as well as other church models was surveyed. How to plant a church and the challenges associated with mental illness were also topics reviewed. The researcher was influenced by the thinking and writing of Rick Warren, Darrell Guder, J.D. Payne, Ed Stetzer, Steve Addison, Lesslie Newbigin, Dr. Matt Stanford, Joe Padilla, Alan Hirsch, Jean Vanier, Jonathan Benz, John Swinton and Amy Simpson, to name a few. Because information changes so quickly and publishing books takes on average eighteen months to two years, published material from the span of the past twenty years were predominantly used. Along with these published materials there were some classic works, including the Bible, that were written prior to the limitation of twenty years that were used.

## Research Methodology

There are a number of questions that could have been addressed in this project. Yet, three main questions were addressed. Firstly, “What are the unique dimensions of ministry with people who have a mental health condition or with people who have family members affected by mental illness?” Secondly, the question will be asked, “What is missing in downtown Orlando that would be help for people affected by mental illness?” Thirdly, “What are some best practices for inviting and including people with or affected by mental illness in the context of a local church?” It is a belief of this researcher that there are misunderstandings and fears regarding the capability of people with mental illness or mental health conditions. This is the basis for these questions and the basis for this project to have a mixed method approach for a Pre-Intervention Research Project. A quantitative method was applied to a survey/ questionnaire that was designed and administered. There was also a qualitative method used for this project with the open-ended questionnaires and unstructured interviews based on the answers given in the open-ended questionnaires.

### Type of Research

In this Pre-Intervention ministry transformation project, both quantitative and qualitative analysis were used to confirm and substantiate the findings. The quantitative analysis was applied in the evaluation of the surveys and questionnaires, and the qualitative analysis was applied to aspects of the questionnaires and the unstructured interviews. The answers given in the interviews were condensed and codified, so the results could be applied to this research project. The researcher made connections with leaders in downtown Orlando to learn what practices are currently being applied in the

context of Orlando and to help in projecting what would be beneficial for the future of the people affected by mental illness in the context of a church.

Phone calls and face-to-face communication were the preferred methods of gleaning information from people within downtown Orlando. After phone calls were made, communication would sometimes move through email interaction. Once surveys and questionnaires were completed, appointments to meet face-to-face were made by phone or through email. In the interviews with the pastors, the research questions listed previously were discussed and them other questions developed as answers were given or their experience with mental illness brought forth new insight. The information gleaned from these interviews was limited by the fact that the person being interviewed had "a stake in presenting their congregation or their identity from a certain perspective" (Sensing 21). This could have propelled the participants being interviewed to give answers to the questions in such a way that may shed a more positive light that what is necessarily true. This would be a normal bias and was taken into consideration when synthesizing the information given. In addition to getting to know people in the Orlando community and talking with pastors, there were in the interviews with people that have a great deal of knowledge in the mental health field. However, the concern for this paper was geared toward how the Church is serving or including people affected by mental illness.

**Participants**

The author of this paper sought to give a survey/questionnaire to twenty-seven adult church pastors or leaders and twenty-five adult community organization leaders from the downtown area of Orlando. In addition to this research there were eight

interviews conducted. There were no particular demographics of these participants except that they were to be leaders in the downtown area of Orlando. The researcher also spoke with leaders who worked in the mental health field or churches in other cities to learn more about their practices to invite and include people affected by mental illness. The leaders who participated gave insight in the needs of people affected by mental illness in the communities where they serve.

**Data Collection**

The survey/questionnaires were collected from the participants through email, mail, or in person based on their comfort level. The researcher did not want to create any discomfort or interruption in the participants' busy schedules. After the survey/questionnaires were collected from those on the lists indicated in Appendices E and F, the data was condensed and reported in the tables as shown in chapter five. If a participant volunteered to give an interview, then the researcher set it up at the convenience of the leader. The information from the interviews in this project, were compiled through notes taken by the researcher and then transcribed. Interviews included questions about how the person being interviewed feels as well as what they have done, seen or think about the topic at hand. As these things were discussed in the interviews, the researcher listened, observed and documented any differences among the responses given. According to research experts like Sensing, as notes are taken in the interviews, observations of the surroundings, repetitions or elaborations of what is said as well when there are silences or hesitations should be recorded (Sensing 110-111). The transcribed interview notes were divided into two categories as follows: Church pastors/leaders on the one hand and community organization leaders in the field of mental illness on the

other. Interviews with experts in the field from other parts of the country were also conducted and used in the findings of this project.

**Data Analysis**

While sorting through the information collected, themes and patterns developed and were documented. There were also things missed or unspoken in the designed instruments or conversations, but this is expected and referred to as "*slippages* or *silences*" (Sensing 197). The "slippage" in the report was not necessarily self-evident, but there was an intentional effort to look for what could have been missed or avoided in conversations and resources. Because of a research process called "*reflexivity*," the researcher considered emotions and bias so it would not affect the interpretation of the results (Sensing 44). The researcher of this project has had personal experiences that have been an impetus for this project. Empathy is necessary for ministering to people with mental illness. However, the focus of this paper must be kept within its parameters. This ministry transformation project has not covered everything there is to know about mental illness or starting a new church but has sought to create a new church model that incorporates dimensions and practices that include people with mental illness through the answering of the research questions suggested.

**Generalizability**

The data collected and analyzed can be trusted, because the administration of the same instrumentation would reproduce the same results. The findings of this project also have applicability to more than the church model being developed in downtown Orlando. The results and the suggested recommendations for further use of the collected data for this project could be used for other faith communities. The significance of this project

confirms some of the findings established in the literature review portion of this project and they have produced insights to address the questions proposed with the purpose of the project.

### Project Overview

This project was meant to reveal practices for a new church model to follow so a model could be duplicated within the Church although the findings may be applied with personalization to the context of the community where a church is planted. As it will be discussed in this paper, God is intentional about sending forth his people and spreading his love and grace throughout the world. Thus, the findings of this research project should be applied in the Church, not just the church planted in downtown Orlando. No two churches are ever the exact same. However, the message of hope and wholeness given in the Gospel is consistent, steadfast, and reproducible. In other words, the recipe created in this research project should produce the same results when followed but personalization in the context of the church should be considered.

## CHAPTER 2

## LITERATURE REVIEW FOR THE PROJECT

### Overview of the Chapter

In chapter one, three reasons were given for why this project should be undertaken: first, God has created humanity to need relationship and thus, community even in the midst of mental illness; second, to fulfill the mission of Christ and His Church to meet people in the margins; third, to stand in solidarity with brothers and sisters struggling with mental illness as a means of respecting that their identity is in who God is and not in what they may think they lack or need. Scripture has ultimate authority for

Christians when considering what do or not do with their life. Therefore, to lay the groundwork for this research Biblical and theological foundations will be laid. In this chapter, there will also be insight from what others have said about these topics as examined with reference to the purpose of this project. The conclusion of this chapter will highlight the important themes and propose how the research will be impacted by the findings.

In order to give a broad overview of this chapter, the sections are described here. The literature review starts with consideration of Biblical Themes addressing these two headings: "What does the Bible say about the church?" and "What does the Bible say about mental illness?" In this investigation humanity's relationship with God and what that means for relationships among humanity will be researched. In addition, what the Bible says about mental illness and what it does not will be reviewed. In the next section, Theological Foundations, there will be several questions addressed. First, "Can claiming an identity in Christ impact the issue of mental illness?" Second, "Why does God allow mental illness?" Third, "Is mental illness related to sin?" Fourth, "Why should we start new churches?" And fifth, "Why have a church including people affected by mental illness?" The answer to this final question comes in listening to how Jesus responds to those that would seem to be on the margins of society in Luke 4:18-19. In the section on research themes, the researcher will share insights on these themes: church planting, church practices and models, and mental illness. In the final section of this chapter, conclusions will be drawn, research tools will be designed, and a summary given that will catapult this research into the next phase of this project to be discussed in chapter three.

## Biblical Foundations

The Bible tells the story of God as the creator of life. As the creator, he has given specific instructions on how to live a reconciled, redeemed life with God through Jesus by the power of the Holy Spirit. Often humanity has failed to live the way God has directed. Therefore, God has given word pictures, parables and prophesies through ordinary people to teach humanity what is needed to have an abundant life and most importantly what is needed to have relationship. One way God reveals himself is through gathering so the question is asked, "What does the Bible say about the Church?" The second question will look into what the Bible says about mental illness. In the letter written to a church leader named Timothy, it says the Bible is God's word for reaching out to his creation through the writings of men for teaching, training, correcting, and inspiring (2 Tim. 3:16).

### What does the Bible say About Church?

Starting with the story of creation, God reveals his nature of being connectional and relational. After God created the heavens and all that inhabits the earth, God created humanity with the intent of including the image of God, "Let us make humankind in our image," as if to identify the complexity of his nature. Throughout scripture God's triune nature is revealed as three in one: Father, Son, Jesus Christ, and Holy Spirit. The nature of the Trinity is seen as the Spirit of God overshadows Mary, so she can conceive the Son of God who becomes known as Jesus, the Incarnation of God (Luke 1:26-38). In the baptism of Jesus, the relational character of God is seen as Jesus is baptized, the voice of God is heard, and the Spirit of God descends from heaven in the form of a dove (Luke 4:21-22).

How the Father, Son, and Holy Spirit are one and the same is a mystery of faith that is not totally explainable. However it reveals the importance of relationship to God. Being made in the image of God, humanity is hardwired to need the communion of relationship with God and with one another. Again, referring to the creation story, God saw that the first human, Adam, needed a companion. So, a female, Eve, was created (Gen. 2:18-23). There was an invisible cord that bound Adam, Eve, and God until these humans accepted the enticement of evil separating their bond. God still pursued Adam and Eve even when they alienated themselves from God. Since this time, God has pursued a covenantal relationship with his beloved humanity. In the Apostles' Creed, which has been used as a statement of faith since the third century after Christ, there is a reference to belief in the "one catholic church" which is another way of saying, "one universal church" (Apostles' Creed: Traditional and Ecumenical Versions-The United Methodist Church). There are lots of small churches or what has become "local churches" included into this one universal Church.

"Church" comes from a Greek term, *ekklesia*, which means "gathering." In the Old Testament, God's people "gathered" for instruction, worship and sacrifice in places like the base of a mountain or at a riverside and later, at the Temple. To bring people together was a means of getting everyone on the same page so there would be unity, order and focus. The people could acknowledge their oneness as God's beloved and honor God's authority in their lives. Over and over a pattern showing humanity accepting and rejecting God ensued. God sometimes sent exhortation and sometimes encouragement through various priests like Aaron (Num. 18), judges like Deborah (Judges 19), prophets like Haggai (Hag.1:3), military commanders like David (1 Chron.

27), and ordinary people like Rahab (Josh. 2). Since nothing could eliminate the separation between God and humanity, God sent Jesus to heal the sick, to release the captives, to give freedom to the oppressed, to proclaim justice and hope for the outcast and to extend his love to everyone. There were times that the followers of Jesus gathered on a mountain or by a river or even at the Temple when he was walking this earth to learn and live into what Jesus had come to do. Jesus' followers gained insight to who God is by following Jesus day-by-day. Jesus brought people together by saying, "Come, follow me" (Mark 1:17). In the all of the Gospel accounts, Jesus called men from various walks of life to follow. When one of them confessed that Jesus was the Son of the Living God, Jesus said that he would build his "Church" on the rock (Matt. 16:18). In the literature reviewed there were various proposals as to whether Jesus meant that the foundation of the Church was upon the confession of Peter or that it was Peter's faith. In any case this is the only time Jesus makes a statement about the foundation of the church although he called and gathered people on many occasions and into "gatherings" at the synagogue. While Jesus was on earth he continued to call people to gather.

After Jesus' death and resurrection, he gathered eleven of his disciples on a mountainside and commissioned them to make disciples, baptizing them and teaching them to obey all they had been taught (Matt. 28:19-20). Jesus was essentially saying, "You must carry on all that you have seen me do and heard me say." When Jesus met with the disciples one last time before he ascended into heaven he encouraged them to "go" everywhere beyond Jerusalem with the Gospel (Acts 1:8), and so they did. A few chapters from the book of Acts describes the tensions between Peter and Paul as they try to decide how to instruct people to live as followers of Jesus Christ after his death,

resurrection and ascension. What is particularly interesting is how the followers were led to relate to one another. In Paul's letters he refers to those within the churches as brothers, because there was great loyalty and high regard for families in the Mediterranean cultures. It could be that Paul was suggesting that churches are like surrogate families (Hellerman 82). The church was not meant to be a collection of individuals, but a new group that shares life like a family. This thinking was not from Paul but could even be heard in the teaching of Jesus when he said, "Who is my mother and my brother?" (Matt. 12:46-50). He does not mean to negate the role of one's family but to use it as a reflection of how the church should be connected or bound to one another for unity, order, support, and loyalty. Paul also substantiates the connection of the church as family in the letter to the Galatians when he suggests that they are all "sons of God through faith in Jesus Christ" who is an heir of God, whom Jesus called, "Abba, Father!" (Hellerman 96).

The Church has been called the body of Christ as a metaphor to accentuate the diversity of the people (Rom. 7:4, 1 Cor. 12:12-31). Several scriptures list various gifts needed to build up the church just as a body would need its ear, foot, or mouth. The gifts are individually given for the purpose of the whole church family (Rom. 12:4-8, 1 Cor. 12:7-11, Eph. 4:11-14). The church is also considered the bride of Christ who partners with Jesus to make his kingdom known on earth as it is heaven (2 Cor. 11:2, Eph. 5:32, Rev. 22:17). Just as a bride and groom become one by laying down their lives for one another in the covenant of marriage so the church is to partner with Jesus Christ in a covenantal relationship for oneness laying down their lives for their brothers and sisters (John 17:22-23).

There is one mission. The marks of what it means to be a church are the "work of faith, labor of love and steadfastness of hope" (1 Thess. 1:3). C. S. Lewis summarized it like this: "the purpose of the church was to draw people to Christ and make them like Christ" (quoted in Hirsch 102). As the church represents Christ in the world, the Church carries the values of compassion, kindness, humility, meekness, and patience (Col. 3:12-17). The Church is invited to participate in the sacred ordinances of Baptism and the Lord's Supper. We Christians are to encourage one another in spiritual disciplines and study of the Word. Christians are to help each other in times of need and rejoice with each other in times of joy. Christians are to proclaim the message of salvation to the world. Christians are to equip and send forth people in the ministry. Christians are to seek holiness, so they will be set apart and sanctified.

**What does the Bible say About Mental Illness?**

There are different references in scripture to madness or insanity, which indicates people saw symptoms of mental illness through out the history of God's people. Because the Bible is made of laws, stories, prayers, and songs that has the transparency of people's thoughts, feelings, and behaviors the brokenness of humanity and the presence of mental illness or mental disabilities is obvious. The people of the generations recorded in scripture may not have known how to care for people with mental illness, but there are things to learn from these pages about who God is, who people are to him and how people should care for one another.

There are two terms used in the Old Testament to refer to behavior that seemed out of the norm: *shagha* and *halal* ("Madness" Sakenfeld 765). In the Jewish law, mental instability was considered an affliction that could affect a person if they were disobedient

(Deut. 28:28). Within the writings of the prophets Jeremiah, Hosea and Zechariah there are references to people who were overcome by "madness," meaning they were not in their "right" mind (Jer. 29:26, Hos. 9:7, Zec. 12:4). One of the saddest stories of the Bible is Saul's pride that leads him out of his rule as King and into irrational behavior that the DSM5 (*The Diagnostic and Statistical Manual of Mental Disorders*) of the twenty-first century would describe as manic and depressive (1 Sam. 16:14, 23; 18:10; 19:9). In the wisdom literature of Solomon, madness is associated with foolish behavior (Prov. 26:18-19, Ecc. 1:17). There are also times that people like Saul and David who "acted mad" in order to alienate people with fear in a situation (1 Sam. 21:13, 15). And finally, King Nebuchadnezzar suffered a short period of time with "madness" by acting like an ox eating grass as a lesson from God (Dan. 4:29-37).

Beyond "mad" behaviors in the Old Testament, there were moments of depression, desperation, being downcast, troubled or miserable in the lives of many characters in God's story. Elijah went into such a deep depression that he wanted to die (1 Kings 19:1-10). This state of despair came even though he had just seen God send fire from heaven to burn up the offering set before him and he had also experienced God's power to overcome four hundred and fifty Baal worshippers (1 Kings 18:20-40). Jeremiah was known as the weeping prophet who wrote the book of Lamentations as he suffered from depression, which was triggered by the deep sadness of the Israelites after the destruction of their Temple (Jer. 15:10-18, 20:14,18). Job and Hosea showed signs of depression that developed after calamity fell upon them when they lost family members. Job even suffered boils that made him curse the day he was born (Job 10:1). In the book of Jonah, it says he was in such a state of depression that he wanted to die (Jon. 4:3). In 2

Samuel 12:15-33 and 18:33, King David's depression was triggered by the death of his sons. In the psalms are the examples of prayers David lifted up when facing desperation in battle or the consequences of poor choices like committing adultery. Throughout the psalms, depression and anxiety are emotions expressed. People in earlier centuries and in today's world, use these psalms as prayers when searching for ways to make sense of their mental, emotional, relational, physical, and spiritual state.

In the New Testament when a person's behavior was controversial, the Greek words used were *mainomai* (John 10:20) and *paraphronia* (2 Pet. 2:16) ("Madness" Sakenfeld 765). When Jesus' family heard about how Jesus was speaking, healing, and gathering people in public, he was called "insane" by his family and by Jewish leaders (Mark 3:21, John 10:20). The apostle Paul was called insane by the leader named Festus and then he called himself "mad" as he described how different his behavior was from the norm as a servant who suffers for Christ (Acts 26:24-25, 2 Cor. 11:23). These references may not mean that people actually thought Jesus or Paul were "insane." These stories indicate that people used words even in the first century to try describing a behavior that seemed abnormal or unstable.

Depression and anxiety are mental illnesses evident in the New Testament. In Matthew 6:25-34, the gospel writer shares Jesus's encouragement not to allow one's anxiousness to drive their behavior because God has even taken care of the lilies in the fields. Some manuscripts translate this word that means anxious as "worried," which is a very different concept that having an anxious panic attack. The reference sheds light on the struggle modern people have in how they talk about mental illness. The Apostle Paul tells the Philippians, "Do not be anxious about anything" as if to reiterate what Jesus had

said along the Sea of Galilee (Phil. 4:6). In a letter from the Apostle Peter, people are encouraged to "cast all their cares (anxiety) upon the Lord" (1 Pet. 5:7). Jesus, Peter, and Paul all acknowledge a struggle with anxiety and deep anguish of despair. In Matthew 26:38, Jesus is described as one who is in anguish, "even to the point of death," while he is praying the night he was arrested. This passage demonstrates that it is a part of the human experience to deal with suffering. Not all despair is related to a full blown case of depression but these stories reveal that even the Son of God faced the brokenness and suffering of humanity. This would indicate that mental illness is not simply a spiritual issue.

It has been argued that describing someone with demonic possession in the Bible was a way of describing a person will severe mental illness and others have argued that there really is a spiritual realm that sends forth demonic spirits that affects one's mental and physical capabilities. The Old Testament has a variety of texts that describe an evil spirit and several that show God is involved in the situations where good and evil spirits were present. For example, in the book of Job, the Adversary or Satan who taunts Job in an effort to lure him away from a relationship with God is shown to be in conversation with God and affecting Job's mental capacity (Job 1-2). In the book of Zechariah Satan is rebuked by the Lord in a vision (Zec. 3:1-4). And a third example of the Old Testament, is in the story of Saul who was described as being tormented by an evil spirit sent by God after his disobedience (1 Sam. 16:14).

Jesus healed people from demon possession more than any other form of healing. According to several sources, a person with mental illness in the New Testament would have been considered demon possessed. However, not all demon possession should be

equated with mental illness, because there was and still is a struggle with evil forces in the world. The New Testaments stories of Jesus healing people from various sicknesses or casting out demonic spirits reveals the authority of Jesus over all things whether the physical, mental or spiritual (Matt. 9:32-33, 12:22, 17:14-15; Mark 1:32-34; 5: 16-18; 7:26-30, Luke 4:33-35; 8:27-35; 9:37-42, 13:10-16). The emphasis Jesus placed on healing does not indicate that the world would be cured of physical or mental illness but it points to the healer and hope for all illness.

The book of Deuteronomy of the Old Testament was an important tool in teaching the Israelite people how to live. One of the most quoted scriptures comes from the sixth chapter, it says: “Hear, O Israel: The Lord is God, the Lord alone. You shall love the Lord your God with all your heart, and with all your soul, and with all your might” (Deut. 6:4). This scripture was so important to the Israelites that they would write it down and put it in a leather case then tie it to their forehead as means of reminding themselves that all authority in their lives needs to be given to God. In the first century, Jesus was asked which commandment was the greatest, he responded: “Hear, O Israel: The Lord our God, the Lord is one. And you shall love the Lord your God with all your heart and with all your soul and with all your mind and with all your strength.’ The second is this: ‘You shall love your neighbor as yourself.’ There is no other commandment greater than these” (Matt. 22:35-40). To focus one’s life on God’s will and not one’s own requires heart, soul, mind, and strength. This is difficult when a person is suffering with a persistent mental illness. The mind is equated with one’s will and their ability to make decisions and affects a person’s body and spirit. In what appears to be a seeking of understanding in the connection between Christian faith and mental health, the apostle Paul wrote in a

letter to the church in Rome: “Do not be conformed to this world, but be transformed by the renewal of your mind, that by testing you may discern what is the will of God, what is good and acceptable and perfect” (Rom. 12:2). In a letter to the Philippian church he suggested: “Let the same mind be in you that was in Christ Jesus” (Phil. 2:5) And in a letter to the Corinthians he wrote about how he has the mind of Jesus Christ which gives him instruction for spiritual discernment as to what truly leads a person into knowing and following Christ Jesus (1 Cor. 2:6-16).

## Theological Foundations

### Can Claiming an Identity in Christ Impact the Issue of Mental Illness?

In the story of creation, God’s desire to share love was revealed when he created humanity to bear his image (Gen. 1:26-27). When a person chooses to live in and with the truth rather than in fear and shame that person has the opportunity to claim that they bear the image of God and an identity in Christ. There has been a struggle with mental illness since sin separated humanity from God as recorded in the Garden of Eden but humanity may not have always understood mental illness let alone what it is to be mentally healthy. God is a God of otherness who sent His son, Jesus Christ, into the world to rip the veil between humanity and God so people could be connected with love and truth in the present and forever instead of separated by sin or the brokenness of this world. It is important for people with mental illness to know that God loves them no matter what they have done or not done. A person’s identity is not wrapped up in their illness or their health. By the grace of God each person is created by love. God wants His people to be in relationship with Him and in community of other sons and daughters.

Within the womb of a woman a human life develops “fearfully and wonderfully” and then is given breath from the author of life, God (Ps. 139). The Bible holds many stories of people who have struggled with mental illnesses like the obsessive behavior of King Saul (1 Kings 19: 4-10), or like the depression and suicidal thoughts of the prophet, Elijah (1 Sam. 16: 15-16), or the irrational, isolating habits of a Samaritan woman as described in John’s Gospel (John 4). God meets everyone where they are and loves them into transformation from brokenness into wholeness.

The weakness in a person is not to be hated. It is to be embraced. Even within the womb God knows there are aspects of a person that the world may consider weak or even detestable. Yet God sees a reflection of beauty and hope not the weakness or any disability. Jean Vanier summarizes Dietrich Bonhoeffer’s poem, which he wrote in prison for attempting to assassinate Adolf Hitler while questioning his identity and purpose. Bonhoeffer asked, “Who am I? Am I the person who is prison is seen as peaceful and strong an about whom everybody is saying how wonderful you are? Or am I that weak person inside of me who is filled with fears and with anguish (Swinton and Vanier 91)?” Vanier goes on to say that a person ought not be identified with their church or anything. Ones’ strength comes in their identity in Christ.

God is relational. As Triune God the Father, God the son Jesus and God the Spirit, it is evident that God seeks relationship. Humanity is given the opportunity to accept a relationship offered by God. As loves flows from God into a person, they are given a call to reconcile with themselves, with others and with all creation (adopted from Bryant L. Myers by Corbett and Fikkert 55). This vision for people living into what it means to bear

the image of God is critical for all humanity including people in the margins or people with mental health conditions.

As people created in God's image, humanity is called to be in relationship with one another. As humans seek understanding of what it means to be in relationship, identity in Christ reveals that just as Jesus is connected with the father and the Spirit so it should be between humans. If humanity were to seek reconciliation in relationships the way God seeks relationship with each person, the world would be a different place. What if people sought to see Christ in each other? What if people sought to love each other as whole persons even with flaws and brokenness?

## Why does God Allow Mental Illness?

During the research of this project, the history of psychology and how the mentally ill were treated brought confirmation that generations have struggled to find answers to how the Christian faith can bear witness in the lives of people with mental illness. The knowledge of a person's understanding of what mental illness is or is not may affect how they see their relationship with God. Some people over spiritualize it and think God is making them suffer because of something they did or did not do. Some people blame Satan and say Satan is the one who brings demons to haunt people with mental instability or hallucinations. Some people dismiss mental illness by saying God set the world in motion. So people have to pull themselves up by the bootstraps when life gets tough. They figure out how to live in their own strength and expect others to do the same. Some people do not believe there is a God. So mental illness is really an illness that needs to be addressed medically. And some people know that mental illness is multifaceted and hard to understand. It is not a punishment but a consequence of living in

a world prone with sin. Mental illnesses and mental health conditions affect people in multiple ways. As a result, there will need to be multiple, creative ways to address the physical, spiritual, relational, and mental symptoms of them as well as their emotional expressions such as: pain, hopelessness, frustration, shame, grief and fear. The Church needs to seek understanding of sin, suffering and God's love as she ponders why God allows mental illness.

**Is Mental illness Related to Sin?**

Because this world is affected by generations of sin, a human's body, mind and spirit does not work in the perfect way God designed for it. Sin has affected the world since humanity was first created and has continued to separate humans from God and one another. God does not send mental illness because of sin. It is a part of the suffering in this world. Each person's action or inaction affects the brokenness and suffering in the world, but there is more to it. Sins are not merely corrected by the repression of thoughts or actions. People have choices about how they want to respond to the brokenness and messiness of the consequences in their own lives and that of others. These choices have less to do with sin and more to do with relationships with God and others. God allows people to choose to turn to him to ask for strength to deal with suffering like mental illness or not to choose turning to him.

Dr. Matthew Stanford explains how the body, mind and spirit are interrelated in his book, *The Biology of Sin*. He describes the purpose of the elements of a human. First, bodies make connections to the physical world through senses. It is a vessel for containing the mind and spirit (Gen. 1:27, 2 Cor. 5:1-4). Second, the mind is where a person "interact[s] with God through prayer (1 Cor. 14:15), receive[s] divine revelations

(Luke 24:45), and [is] transformed by the indwelling Holy Spirit" (Rom. 12:2) (*The Biology of Sin* Stanford 17-18). Third, the spirit is given by the "breath of God" (Gen. 2:7) and is the vehicle for which humans have closeness with God (Rom. 8:15-16). The Spirit of God is given to a person to live within them to transform them (John 4:24). All humans are sinners and in need of grace to align each with God and one another. Within scripture, the words, *"chata"* and *"hamartia"* are used to describe sin at "missing the mark" or "falling short, of the glory of God" (*The Biology of Sin* Stanford 3). As Stanford suggests, people ought to consider the glory of who God is, when people focus on sin rather than putting their focus on what a person should not do. When focus is on sin, a person misses who God is. In Romans Paul writes, "The mind set on the flesh is death, but the mind set on the Spirit is life and peace" (Rom. 8:6).

God dealt with sin, by sending his one and only son into the world to pay the price needed to bring humanity into a right relationship with God (2 Cor. 5:21, 1 Pet. 2:24). God dealt with suffering as a human when many rejected him, denied him, scoffed at him, tortured him and crucified him (Luke 4:14-30, 22:54-62, 63-65, 23:32-36). God took on this suffering as a means of solidarity in love with his created people (Stott 320). Life springs forth from death. Jesus came forth from a tomb. Forty days later, he ascended into heaven and then ten days later sent his spirit to dwell in the hearts of those who confessed Jesus as Lord.

While accepting Jesus as Lord and savoir brings wholeness, that person is not exempt from the suffering of illness be it mental, emotional, physical, or relational. Perhaps the question ought to be: "God, where are you in the midst of mental illness and suffering?" There are scriptures that point out God's presence during battle (Deut. 20:3-

4) or in moments of being "brokenhearted and crushed in spirit" (Ps. 34:18) The Apostle Paul encourages those who are in pain to remember that their afflictions will be used to give comfort to others going through similar hardships (2 Cor. 1:3-7). On the website of Saddleback Church Mental Health Ministry, Pastor Rick Warren states: "Your greatest ministry will flow out of your greatest pain" (Hope4mentalhealth.com Warren) In other words, Warren reiterates Paul's point. Whatever suffering a person is going through, God can use to bring comfort and hope. The Apostle James said it this way: "Whenever you face trials of any kind, consider it nothing but joy, because you know that the testing of your faith produces endurance; and let endurance have its full effect so that you may be mature and complete" (James 1: 2-4). We tend to want to avoid suffering yet in the midst of it God can teach us and then use the suffering to bring a connection of love and growth with resilience.

In *The Cross of Christ*, John Stott explains how God uses three images as an analogy for how suffering can bring about maturity (Stott 308). The first image is a father giving discipline to children (Deut. 8:5, Heb. 12:5-11). The second image is the refining of gold and silver by a metalworker (Ps. 66:10, Zech. 13:9, 1 Pet. 1:6-7). And the third image is the pruning of a vine by a gardener (John 15:1-8, Is. 5:1-7). These are examples of how God brings life or beauty through hardship. Jesus says to come to him in the midst of our weariness (Matt. 11:28-29). Jesus does not say he came to alleviate it. He saves us from separation from him and asks for us to come to him in the suffering of life.

**Why Should We Start New Churches?**

The Bible does not give a command to start new churches. Instead there is a command from Jesus to make disciples (Matt. 28:19-20). When disciples gather, they are

the church (Acts 14:27). A disciple is a learner as well as a follower of Jesus. A church has the opportunity to gather in common-unity filled by the Spirit as followers of Jesus Christ to proclaim healing, hope, love and grace. Because there are still people who have not heard the Gospel, there is still a command to testify which in turn will create new churches.

A common theme in books on church planting is the parable of the sower from Scripture. The parable is an analogy for planting churches. In the parable, a follower of Jesus is the sower. The Gospel is the seed. The hearts of humanity are the soil nurtured by the Spirit for the seed to take root and grow (Luke 8:4-15). God is generous with the Gospel and with the nurturing of the Holy Spirit. The parable acknowledges that some will reject the Gospel, and others will receive it. Some people will be transformed to the extent that they become sowers that sow one hundred percent more. A lot of churches have been established based on the gifts of the church planter rather than the testimony of the Gospel. J.D. Payne and others suggest that church planting should be more about evangelism. This is a term for what a follower of Jesus does with the good news of Jesus. It is the result of how the good news of Jesus, and the indwelling of his Spirit, has transformed a person into a follower of Jesus with a passion to testify to the goodness of God to anyone and everyone (Payne 17). Until the witness of Jesus has gone to the “ends of the earth” there will be a calling to sow the gospel, which will start new faith communities (Acts 1:8).

## Why have a Church Including People Affected by Mental Illness?

Early on in his ministry, Jesus visited the synagogue in his hometown, Nazareth, where he read the text of the prophet, Isaiah, as an announcement that the kingdom of

God was at hand (Luke 4:18). Jesus read the section about “bringing good news to the poor, release to the captives, sight to the blind, freedom to the oppressed and to proclaim the year of the Lord’s favor” (Luke 4:18-19). The Gospels contain stories with people being healed, or gaining sight, or being released from captivity of the demonic indicating that God cared for those that are ill or rejected. In the personal experiences reviewed in articles, books and websites for this project, people living with or affected by mental illness have testified that they have felt hopeless, captive, invisible or oppressed, which will be discussed in the next five sections.

**Good News for the Poor**

Even when Jesus walked the earth there was poverty. What was the good news for them? Jesus did not have fundraisers or seek donors to give money to provide for the poor. He did not open soup kitchens or thrift shops to provide for the poor. As a matter of fact, while eating dinner at the home of Mary in Bethany, just days before Jesus was crucified, Jesus received the lavishness of expensive perfume being poured on his feet. Instead of suggesting it be sold it to provide for the poor, Jesus received the gift (Mark 14:3-9). There are over four hundred verses that mention tending to the needs of the poor.

In the gospel of Matthew the poor are described as being “poor in spirit” (Matt. 5:3), which is also a phrase used in the historical Dead Sea scrolls (“Commentary on Matthew” Keck 178). This reference refers to a lack of confidence or insecurity about one’s identity as God’s (178). Luke’s reference is focused more on the lack of material goods. Whether in the first century or the twenty-first century to be poor means they lack power, lack of hope or freedom to make choices in their life, which inhibits reconciliation

with God and others (Corbett and Fikkert 74). Jesus brought good news by bringing freedom from the penalty of sin and hope for a new life in Christ (1 Pet. 3:18).

In America, a quarter of the population lives with a mental illness (www.namigo.org). In 2014, only fifteen percent of the population would have been considered poor ("US Census Bureau Poverty Main Page"). Not all with mental illness are poor according to economic standards but they could still be considered poor according to the suggested definition that poverty is equated with powerlessness and brokenness. As recorded in many of the stories included in the research, people affected by mental illness feel powerless in a culture that has a broken mental health system and many churches who do not know how to address the shame and injustice around this issue. Sometimes this leads to lack of material goods but not always. There needs to be a holistic approach to caring for the "poor."

When Jesus said he came "to proclaim the good news to the poor" he wanted to offer his power that would result in reconciliation and redemption in their lives. The good news of Jesus is that he came into the world to be the provision for a relationship with God who gives power of forgiveness, love, and peace even in the midst of suffering. In a sermon Jesus gave known as the Sermon on the Mount, he said, "Blessed are the poor in Spirit because they will inherit the kingdom of heaven" (Matt. 5:3). Those affected by mental illness have the God of heaven and earth to care for them. God may not make mental illness or poverty go away in this lifetime, but God promises his presence in the midst of the struggle and offers hope as the gift of his grace is accepted so they can be his children.

In an article by Ujunwa Anakwenze and Daniyal Zuberi, they claim that mechanisms are in place within the urban arenas that contribute to the replicating cycle that keeps powerlessness in the lives of those in poverty. The authors demonstrate that there are a number of things happening in impoverished neighborhoods of the inner city that propagates mental illness and the inability to treat or care for those with mental illness. From joblessness to underemployment to neighborhood violence and disorder, many things undermine lives in such a way that people have a hard time caring for mental illnesses within the inner city. The report of the authors suggests that professionals, including clergy, should invest in the urban areas with education and development of systems that can break the cycles being lived out (*"Mental Health and Poverty in the Inner City,"* Anakwenze). They write:

> Pastoral care can also be an important feature of a comprehensive mental health service plan. Social workers and other practitioners should engage and train urban clergy and lay ministers to provide short-term counseling and referrals for longer term mental health care. Clergy represent a significant mental health resource for people who otherwise lack sufficient access to care. This approach also builds on the central role of the church in many Hispanic and African American families and com-munities (quoted from Young, Griffith, & Williams, 2003).

How many of those who struggle in impoverished environments are also suffering with mental illness? How many of those who have not been diagnosed with mental illness, but carry symptoms, try to blend in with the culture around them so they will not have to deal with the shame or fear related to mental illness? People with mental health conditions

need to feel like they a faith community willing to share life without pushing them to the sidelines.

**Release to the Captives**

There are no stories of Jesus going into prisons to release prisoners, but there are other ways people were held captive. In those situations, Jesus released them. One such occasion happens when Jesus heals the Gerasene demoniac in Mark 5:1-20. Within this story, Jesus is approached by a man who scrambles out of control from the tombs in an area known as Gerasene. Neither shackles nor chains could retain or subdue the man, so why would he be considered a captive? He was called Legion because many spirits held him captive. It is hard to know if mental illness was involved in this case of other stories of demonic possession. A psychologist today may have considered that this man had multiple personalities. Jesus called forth the spirits to leave the man. Then the man was released to clothe himself and be of a “right mind” so much so that he went to the community around him to proclaim what Jesus had done for him. The community in turn was amazed by how Jesus had released this man from captivity of an irrational mental state.

There are daily interactions with people who have mental illness and yet most people do not know how to address them. It is appropriate to call for help in those situations and when the person has been properly diagnosed and received treatment, it is important to walk along side of them to aid in a life of recovery. When there is stability in that persons’ life, it is important to help that person have community and be introduced to Jesus. Jesus told the man to go home to tell his friends what the Lord had done for him. The man freely went to share his testimony. The man was freed not only from the

demons, but free from shame so he could freely proclaim what God had done for him. People affected by mental health conditions need a faith community that is willing to offer hospitality and healing.

**Recovery of Sight for the Blind**

In John 9, Jesus interacts with a man born blind. When asked whose sin it was that caused this man's blindness, Jesus says the man's blindness is a means to see God's glory. This man's condition was not a descriptor for his character, but it was used to point himself and others towards God. His condition was the result of living in a broken world, but it was not a punishment. In the twenty-first century, many Christians have shamed people with mental illness by saying that their illness is an evaluation of their sin or weak faith (*Grace for the Afflicted* Stanford 3). In many Christian circles the response to mental illness has brought forth a suggestion that one with mental illness should pray more or read the Bible more in order to fix their situation ("*Study of Acute Mental Illness and Christian Faith"* LifeWay Research). Dr. Matt Stanford has counseled with many people who said they were rejected by people in their church when they shared that they had with mental illness and in turn had become more depressed and even angry with God as well as the Church. Whether in secular or Christian communities of faith people can become afraid or puzzled by behaviors of persons who have mental illness with the result that they have rejected them or even mock them. These responses have made the stigma of mental illness worse rather than better. It's as if those that are "healthy" have become blind.

Within the Gospels, blindness is used forty-six times, sometimes, literally and other times metaphorically. Using a metaphor, Jesus taught that the eye is "*lamp of the*

*body*" which means the eyes reveal the state of one's heart/mind (Matt. 6:22-23). If a person's heart or mind has no understanding of something then their eyes will have darkness instead of light. There were times Jesus called the Pharisees "blind" because they did not understand that the kingdom of God was at hand in Jesus (Matt. 15:1-20, 23:16). There are some church leaders, and a large part of the American culture, that do not understand mental illness; they are blind. There may not be evil intent but misguided fear that unfortunately places people with mental illness in their shadows instead of the light that shines love, grace, and hope.

On the other side of that coin, there are many churches that hold various support groups in their buildings but the culture still promotes the whisper, "Shhh, don't tell anyone my daughter is Bipolar" or "Shhh, don't tell anyone that I struggle with Bulimia." There are people who think they can hide their symptoms or isolate themselves and they do so in an effort to avoid facing the truth of their situation. To be "blind" can keep a person from living in the truth. Jesus said that the truth will set a person free. When the man in the story of John was healed, he gained eyesight and freedom from the oppression of living a life isolated from community (John 8:32). God cares for the blind, the disabled, those that feel alone, and those that feel like they have no hope. People affected by mental health conditions need a faith community where they can reveal their lives without shame or persecution.

**Let The Oppressed Go Free**

God is known as a deliverer throughout Scripture starting with the exodus of the Israelite people out of Egypt to the day of Jesus' resurrection. God is also a rescuer; he rescues people who feel immobilized, oppressed, and forgotten. Jesus sought to be with

people who may be considered marginalized, or disregarded. On one of Jesus' journeys he stopped at a well in a Samaritan countryside and talked with a woman (John 4). It was unusual that Jesus wanted to go through Samaria, because Jewish did not associate themselves with Samaritans ("John" Wright 41). Throughout much of history women have been seen as property to be managed and in the first century men were not to approach women in public (41). In the case of this story the woman must have been oppressed with shame because she isolated herself from others in her community by going to the well of her village in the heat of the day. Jesus shows the importance of listening to the woman and helping her talk openly about her life including the fact that she had had multiple men in her life. In the story the woman was surprised by Jesus' candor. In the midst of their conversation, her eyes were opened to see that she needed something the men in her life could not provide for her. Could she have had an addiction or some sort of mental illness that consumed her life with shame? The story does not say, but the response of the woman to Jesus' gift of grace and acceptance reveals a sense of freedom. In her newfound freedom, the Samaritan woman went back into her village, talked openly about her experience, and invited the people to meet Jesus for themselves. Sometimes oppression is seen through in abusive or neglectful treatment and other times people allow it to be imposed on themselves because of shame or guilt due to illness or poor decisions. God wants his people to live in the freedom of "the way, truth and life" (John 14:6) even in the midst of mental illness.

In the first step of a twelve-step program like *Alcoholic Anonymous (AA),* a person is to admit they are powerless, not in the way spoken about in poverty, but in humility (*Alcoholic Anonymous* 59). To confess powerlessness in this case does not mean

that someone or something else has dominion except for God. The remaining steps of AA suggest that a person needs to surrender to that higher power and learn how to live in the truth with responsibility, accountability, and sustainability. Jesus Christ offers to take the burdens of his people, because he knows the weight that can be manifested in this life (Matt. 11:29). Knowing that each person would need companionship in midst of admitting and dealing with the burdens of life, God designed humanity to need each other and to offer support to each other. When a person is addicted to a substance, they would rather choose it rather than relationship with God or others. This is known as a substance abuse disorder (DSM5). According to the 2014 National Survey on Drug Use and Health, there are 7.9 percent of the people in the U.S. who experience both a mental disorder and substance use disorder simultaneously (*Learn More/Dual Diagnosis*, www.nami.org).

As people live with someone who has a mental illness, they may choose to use a substance as a coping mechanism. In Amy Simpson's book, *Troubled Minds,* she cites a survey in which "more than 25% of the people with schizophrenic mothers reported that they had problems with alcohol, drugs or both at some point" (quoting Brown and Roberts in *Troubled Minds* Simpson 67). This acknowledgement shows the generational effect of bondage with mental illness. In the Old Testament, there are several references to consequences of people's choices affecting generations and this is true in this case as well. People need help to move past poor choices and how to deal with mental illnesses in the generations before them and in their own lives. Sometimes people will find the freedom they need through a process like what is offered by AA, which was developed by Edwin T. and his friend, Bill Ebby, who adopted steps similar from a religious

organization called the Oxford group (www.aa.org). In addition to the twelve-step program for alcohol, there are programs for drug users, sex addictions and overeaters. Among the history and the steps, freedom comes with following through in action like surrendering to a higher authority, confessing wrongs, asking for help, taking responsibility, and being in community. People affected by mental health conditions need a faith community that is willing to distribute living water to those who are going to a well for a drink like the Samaritan woman. They need someone to share the identity of the higher power offering greater freedom than the world has ever known.

## Research Themes

This section will explore the church models and practices are available to reach and minister to people with mental health conditions. Because this project seeks to create a model that addresses the dimensions that are different for ministry with this people group, this section will also consider the topic of church planting to aid in the development of a new church model. The following themes will be explored: the church, church planting, church practices, church models, and mental illness. To undergird the development of a church model it is important to have a solid ecclesial foundation. The second theme will be church planting. The third theme will be “church models” and their strategies. The fourth theme will be church practices. And finally, although mental illness has been discussed under the biblical and theological headings, there will be a discussion on how the topic has been understood and defined throughout history up to today and the implications for this project.

**Church Planting**

Jesus did not enter the world to "start" new churches; he entered into the world to bring redemption and reconciliation between humanity and God. A glimpse of this reconciliation is revealed through the body of people called the Church. Jesus started a movement calling women and men to follow him. The term, *church planting*, is an analogy for churches being established and developing, just as a plant takes root and grows. Church planting, however, is not just about "growth" in a single place; it is about women and men being transformed by the Holy Spirit in such a way that others are drawn to want this for themselves so their testimony multiplies and spreads to other places. Conferences and books on how to start a new church are on the rise. God is at work, constantly doing new things in the midst of this diverse world he created. He is doing new things through the Church. As discussed, some church planting books use the analogy of planting seeds to help with strategies for planting churches. Some focus on the Great Commission (Matt. 28:19). Some focus on the stories on New Testament churches such as in Thessalonica (Thess. 1:1) or in Galatia (Gal. 1:2). Some books focus on Christianity as a movement in which disciples multiply (Ott and Wilson15) and some are more focused on how a church is the expression of the people being reached (Hunter 35). Another focus to consider before planting a church is the question of "Who?" In other words, a church should be planted to reach people who are not currently being reached (Collier 48).

In J.D. Payne's book, *Apostolic Church Planting*, he writes about the practicalities of starting a church with the goal of being imitators of Paul (who imitates Christ) based on his perception of 1 Thessalonians 1:4-6 (*Apostolic Church Planting*

Payne 19). Chapter five of Payne's work uses Paul's first missionary journey as a guideline for what could be used as a "pathway" for a church planter: "Gospel is shared, disciples are made, small groups are started, church planted, Elders appointed" (52). This book is helpful for a church planter who is considering what stages of growth are necessary the following for the making of a disciple. The roles evolve from being a learner into more mature roles like being an explorer, evangelist, teacher, developer and mentor.

A common thread of church planting resources is the search for a "person or persons of peace" who would be the catalyst for inviting people into the community of faith being planted. This person or persons would be someone who is receptive to the Gospel and excited about the movement of the Holy Spirit in their lives. After giving their life to Christ, this person would be the evangelist in the neighborhood, or extended community, inviting others from their own community to participate in the body of Christ. This concept comes from examples in the Bible like when Paul and Silas met a woman named Lydia and her friends who accepted the Gospel of Christ and then shared what they received with their household. As a result of their openness to the good news, Paul and Silas went with Lydia to her home where her whole household received the gift of salvation. Shortly after being in Lydia's home, Paul and Silas were put in jail. While in imprisoned they praised God through song, and in a supernatural movement, the walls of the jail crumbled, which gave Paul and Silas the opportunity to go to the prison guards' home where everyone in that household was then baptized (Acts 16:14-15, 32-33). These stories reveal Lydia and the prison guard as "persons of peace."

Stuart Murray starts his book on church planting by discussing a theological framework because he recognizes that a person's theology will influence the church that is started and how it functions. Because the church is sent into the world, Murray talks about mission as an important part of the framework for starting churches:

> Theologians refer to the acts of God, rather than the activities of the churches, God is the Missionary, who sent his Son and sends his Spirit into the world, and whose missionary purposes are cosmic in scope, concerned with the "restoration of all things," the establishment of shalom, the renewal of creation, and the coming of the kingdom of God, as well as the redemption of fallen humanity and the building of the church. Mission has a Trinitarian basis and is theocentric rather than anthropocentric. Mission is defined, directed, energized, and accomplished by God (Murray Loc 398).

The conversation on how to be in mission will continue in the section on church models as the concept of being a "missional community" is considered as a model for this research project.

**Multiplication versus Planting**

Several books on church planting have referred to multiplication as an integral action to be taken by a church after it is planted. In some stories the number of churches that have started in an area has been so rapid that a term, church planting movement (CPM), has developed. Church planter and author, David Garrison interchanges the word, "planting" for "multiplication" and defines a CPM as follows: "a rapid multiplication of indigenous churches planting churches that sweeps through a people group or population segment" (Garrison 2). Steve Addison uses the term, "pioneering," when he talks about

the need for apostolic leadership like Jesus in creating multiplication movements (Addison Loc 42). The Bible does not give any directive for how to start a church planting movement, however, the book of Acts reveals the story of how the Spirit has moved in the lives of various people who then participated in the multiplication of churches. Garrison, Stetzer, Addison and others believe "rapid multiplication" is the linchpin in the definition of a CMM (Church Multiplication Movement). A CMM indicates immediacy and an exponential growth quotient over multiple generations; a CMM is an exponential increase in which church growth is doubled in ratios like from two to four to eight and to sixteen and so on. A CMM is not a linear method that goes from one church plus one church equals two churches. Within the online discussions of our class, we debated as to whether the speed of multiplication should be a priority in the development of churches; the concept of simultaneous growth seemed to be an indicator of success that needs to be acknowledged, but also the emphasis on affecting an indigenous people group with real life change is imperative. What seems to affect success is represented in the focus of strengths and the opportunities that lie ahead in the multiplying movement.

The Ferguson brothers, Dave and Jon, sat in a restaurant one day drawing circles on a napkin while discussing a dream to have multiple sites of New Thing church in Chicago, Illinois. Without any training these brothers met with two others in their dorm and started casting their three-prong vision for impacting people who didn't know Jesus, committing to creating a reproducible church, and then to reproduce more churches on a global scale. Their mission was: "Helping people find their way back to God" (Ferguson

22). After getting started they decided they needed a discipleship plan so they created a principles to live by (Ferguson 25-29):

1. “Reproducing requires everyone to have an apprentice”
2. “Reproducing is to be proactive, not reactive”
3. “Reproducing is not about size; its about leader readiness”
4. “Reproducing isn’t about your kingdom; its about God’s kingdom”
5. “Reproducing happens on the edge and in the center”

The Ferguson’s plan seems to reveal a model for “cell churches” and it has shown fruitfulness. These guys like to keep growing, changing, developing, and multiplying. Their energy even from a book is inspiring. Because movement seems to be important in the plans talked about in this paper, here is the Ferguson perspective: “Movement is created when you influence other people to join you by inviting them to share life together and travel at a constant spiritual velocity” (Ferguson 31). Churches began out of people meeting people in the midst of their lives whether waterskiing or watching a toddler and then reading a little scripture and praying for one another. The Gospel was shown and then it was spoken into. They developed a pattern of following Christ then going in mission and then claiming the community of faith.

**Church Models**

There is only one Church, and yet, there many expressions or models of church. Craig Van Gelder suggests there are three visible expressions of the church: Established, Corporate or Missional (Van Gelder 73) To be an established expression is to be a church with more focus on a geographical location. To say a church is corporate is to say it is an organization focused on bringing action on God’s behalf in the world.  To be missional is to be focused on the role of being sent into world to participate where God is already at work.

The following models will be considered in this project: institutional, missional, recovery, fresh expressions and house church or table fellowship. Within these models are many types of people with many types of vision. Some claim to have vision for being multi-generational or multi-ethnic, and sometimes these models may focus on a particular ethnic group. Sometimes a church may focus on a worship style like contemporary, or traditional, or a lifestyle like the cowboy church. Always, the church represents and proclaims the Triune God. There are many styles or descriptors for a church. In this section, models and practices will be discussed. J.D. Payne explains the difference between models, methods or practices:

> A method is a way of doing something—a plan, a system, an approach. Applied to church planting, it is the system we use to plant churches. Models are the expressions of the church that come into existence by the use of particular methods. Church planters must understand that their ecclesiology will influence the methods they use and the resulting models (*Discovering Church Planting* Payne Loc 539).

Practices could be described as those values or actions taken to support the model chosen. The five church models that will be discussed here are not an exhaustive list yet they each have something to offer for the task suggested.

In Stuart Murray's book, *Church Planting: Laying Foundations*, he lists types of churches as "seeker friendly," "network churches," or "cell churches" (Murray Loc 1596). Seeker friendly churches are meant to be invitational and can grow on a massive scale like Willow Creek out of Illinois. Network churches are unified by their purpose or connection to a particular cause rather than connected by a geographical area. Cell

churches are all connected as “one church” replicating in small ways throughout a geographical area. Their size does not identify them, but their mission focus does.

**The Institutional Church**

Some might argue that there is not an institutional church rather it is a corporate or established organization. The body of people developed within this model tends to have a more formal business-like approach with systems for making decisions, setting budgets, selecting leaders and creating programs. The institutional church comes in a variety of sizes such as: a mega church with over five thousand members, multi-site churches with several hundred at each church campus, churches centered with a missionary approach to particular ethnicities with more or less than five hundred people, or smaller traditional churches with less than one hundred people. There is usually a brick and mortar building with a focus on gathering in this particular setting. This model of church creates incredible opportunities for programs and ministries, but this strength can also be its greatest weakness. In the history of the church as church buildings have multiplies so have budgets and inward focus. It could be said that the institutional church is more headquarters- based rather than mission-field based.

Several books suggest the Church has struggled with maintaining its institutional structure rather than remembering its’ purpose to be an instrument in the world. The church will not be what God has created it to be if there is no action taken to play the instrument; music is not music as a collection of notes placed within a staph on a piece of paper. The church is an instrument invited to play the notes through which music is sent into world as the Masterful musician, our God, sends it (or plays it) by movement of the Holy Spirit. In other words, the systems can be the greatest asset of the church because

layers of resources can be accumulated, developed and distributed. Yet it can be its greatest weakness as this model of church can move away from growing in relationships such that the church begins to focus on preserving and maintaining.

**The Missional Model**

There is a renewal movement that has been rising to the surface suggesting that the Church should recapture the *missio dei* rather than creating programs that take people on short-term mission excursions, which can result in a shallow faith with short term affects. Mission projects are good and short-term mission trips can provide amazing experiences that affect a person's perspective of who God is and what their relationship is in the world. However, the goal of the missional church is to be the outflow of the Holy Spirit into the world as the witness of Christ. Alan Hirsch, author of *The Forgotten Ways*, suggests that the core vision of a missional church should be developed through their role of being Christ in the world. Hirsch uses the analogy of the human's DNA code, which affects a person's ability for life and replicating as an image for understanding that the missional thrust of a church's ability for life and replicating will stem from their DNA. Alan Hirsch says that there are six elements that are vital for a missional church DNA (also known as mDNA): Missional Incarnational Impulse, Disciple Making, Communitas, Apostolic Environment, and Organic Systems (*The Forgotten Ways* Hirsch 75). At the core of this DNA is the lordship of Jesus Christ transforming the church's life as personal lives are changed.

In David Bosch's book, *Transforming Mission,* he suggested, "Mission was understood as being derived from the very nature of God . . . Father, Son and Holy Spirit sending the church into the world . . . a movement from God to the world. There is a

church because there is a mission, not vice versa" (Bosch 390). The Church has its mDNA hidden under the rugs of its structure or as Hirsch would say, it has been forgotten by some. Missionary, Lesslie Newbigin, emphasized the term, missional, after returning to the U.S. from India because he was concerned about the decline of the Church. Being missional is in the practice of the church. Likewise, Hirsch is urging the Church to allow it to be a part of the DNA so ministry can flow.

A host of "missionaries" have taken up the mantel to springboard the missional movement into the world, particularly Alan Hirsch, who has written extensively on the subject and incorporated an agency, Forge Mission Training Network, to equip and send out more people with a heart to see God's vision for the Church to be missional. In Hirsch's book, *The Forgotten Ways,* he shares about his journey to uncover how the number of Christians multiplied exponentially from 25,000 in the first century to 20,000,000 in the third century (Hirsch 18). In the mid 1990's in the quest for answers to this query, he and a team of folks experimented with what is now referred to as a missional church model. They set up what they called, proximity space, a "café," which was used for opening conversations on the Gospel, build relationships and offering of services like art classes, book discussions, CD promotions, open mic night, etc. From the café, people would be invited into more "intimate" relationships, through house churches in various neighborhoods. There was a goal to bring people into a commitment of covenantal relationship within the house churches, so their faith could deepen, and their bonds could strengthen (Hirsch 39-41). Missional churches can be house churches, and institutional, or established churches can be missional. The practices listed are what is important in this model.

**The Recovery Model**

All churches have broken people who have the opportunity to experience the reconciliation and redemption of Jesus. However, not all churches have openness to the kind of transparency needed for people seeking recovery and healing with addiction or mental health conditions. People involved in recovery churches are given “the gift of hope” and “a place where vision is renewed, and people are healed” in way that is not happening in many institutional churches (Swanson 5). There are nine churches with recovery ministry that have their stories told in, *Bridges to Grace: Innovative Approaches to Recovery Ministry* by Liz Swanson and Teresa McBean. Swanson would say that recovery is not a “model” for a church but rather a ministry that is vital to have within a local church. Yet some of the Senior Pastors of the mega churches reveal that their own struggles with addictions or mental illness has impacted the DNA of the churches they have planted. In an online article for the *National Association of Christian Recovery*, Dale Ryan extrapolates from a talk given in 2003 for strategies to the recovery movement with the following acknowledgement that churches could be planted with recovery as a focus:

> They want everything about the congregation to be about recovery. The worship. The missions program. The children’s educational program. Everything. There are not yet many examples of congregations who have taken this approach. In this model, ‘recovery’ becomes the central paradigm of the congregation. Participation in recovery becomes as much a part of ‘doing church’ as participation in worship services–in some cases (following Wesley!) participation in recovery groups may be a prerequisite for participation in large group meeting .

> . . It is still too early, or so it seems to me, to know how effective this approach to recovery ministry will be. I suspect we may need to make more mistakes in this direction before we know how to do it well! This is a kind of strategy that it works best, of course, in church planting situations rather than trying to subvert the strategy of an existing church (Ryan NACR Web).

Since this talk was given almost fifteen years ago, churches with recovery in mind have been planted and growing alongside, or bridging with another church, like these three: *Jacob's Well*, in Memphis, Tennessee, *Thrive*, in Tupelo, Mississippi, and *Northstar Community* in Richmond, Virginia.

In the introduction of Swanson's book, she suggested that Jesus was focused on recovery ministry from the start as indicated by his reading of Isaiah's passage in the synagogue:

> It is not a stretch to say that Jesus' first sermon, recorded in Luke 4:18-19, was on the topic of recovery…Recovery begins with the freedom to tell the truth about our lives, the real truth, in a safe place with appropriate people in the body of Christ. God can meet us only where we are, not where we wish we were or pretend we are. Recovery ministry is not a new ministry model but rather an attempt to replicate the ministry Jesus was focused on. He came to seek and save that which was lost (Luke 19:10). Recovery ministry helps many who have lost their way. It forms a bridge to a place they can't seem to find on their own (Swanson 14).

Many churches have recovery ministry communities within their larger church family but this may still be marginalization of such communities. Right or wrong, this seems to

make recovery ministry like the problem child. Sometimes churches allow support groups, whether they have a religious foundation or not to meet one night a week in their building but there is often little or no involvement between those that attend that night and those that attend on a Sunday morning. These recovery ministries also tend to focus on addictions or the healing that needs to take place in the family systems due to co-dependency rather than the various mental health conditions. The twelve step programs bring amazing results for people with various hang-ups, emotional woundedness, and co-dependency issues. However, there is a gap that could be addressed between addiction and mental health. Between these communities, it takes vulnerability and transparency in the church pastoral leadership, to really affect the way a recovery ministry is viewed by the larger church.

An example of a Recovery Church is Thrive; it is a community of faith with individuals, seeking recovery one day at a time, as well as gathering regularly as a whole community along the outer edges of Northwest Tupelo, Mississippi. They focus on healing and wholeness in Christ rather than what is broken in their lives. Their vision encourages a life that is thriving in reconciliation with Christ, rather than a life set in survival mode, due to the host of problems that arise in life. They seek transformation rather than knowledge and companionship rather than independence. Thrive was given birth through the support of The Orchard Church in Tupelo, Mississippi, under the leadership of Reverend Colby Cuevas in August 2015. Temporarily, Thrive meets for their gathering weekly on Thursday nights within the building hosted by their “mother” church, The Orchard. Their weekly gathering schedule is organized as follows. First, they share a meal and visit with each other. Then, they have an hour for singing, praying,

reflecting on the twelve-steps of the recovery process and listening in a time referred to as music and a message. Then, they have support groups according to gender or topic like co-dependency, grief or substance abuse. It does not matter what religion, gender, ethnic or social status the participants come from. According to their website, all are welcome to "share, ask questions, or just come & hang out" (www.thriverecovery.com). To fulfill their mission of helping people thrive, their strategy includes the following three-tier approach: *reach, recovery, release*. Thrive *reaches* out to those who seek answers to their questions about faith and relief to whatever pain or chaos they are experiencing. This community helps people onto the road of *recovery* with those who want to do the work of the twelve steps, which includes surrendering their lives to God, accountability in relationships, as well as setting healthy boundaries. Finally, Thrive *releases* those ready to move into service for others as they accept responsibility to participate in the reconciled relationship they have been offered.

In Jonathan Benz's book, *The Recovery Minded Church*, he suggests that churches should cultivate particular practices to create a "recovery-friendly" community like: long-term sobriety, ending shame, attentive listening, and practice of healing. Of particular interest was his focus on the practice of healing:

> There is a difference between curing and healing, and I believe the church is called to the slow and difficult work of healing. We are called to enter into one another's pain, anoint it as holy, and stick around no matter the outcome-Rachel Held Evans, Searching for Sunday (Benz 142).

In many churches, healing is associated with curing rather than the concept of reconciliation with God in the struggles of suffering. Jesus went through physical,

relational, mental, spiritual and emotional suffering just like all of us and yet Jesus spent just as much time talking about healing as he did about the kingdom of God. Talking about healing, praying with people for healing, walking alongside people who need healing is a critical part of a faithful witness of Jesus Christ. It is noted in Benz' book that healing requires work on the part of the person in need of healing (Benz 147). God is a God who encourages discovery and gives beautiful "aha" moments along the roads of recovery even if there is not a full-blown cure. It is a beautiful thing to see a person give glory and honor to God even in the midst of suffering; this is what is meant by loving God with one's heart, mind, and strength.

**Fresh Expressions Model**

In an effort to reach people in the United Kingdom who were outside of the church, a missional movement was created by DAWN (Disciple a Whole Nation) in the 1990's (Moynagh Loc 115). Michael Moynagh, in his book, *Church for Every Context: An Introduction to Theology and Practice,* gives understanding to the "fresh expression" of church as a "new contextual model" for birth and "growth of Christian communities that serve people mainly outside the church, belong to their culture, make discipleship a priority and form a new church among the people they serve" (Loc 99). In 2004 a partnership was formed between the British Methodist Church and the Church of England. Then the movement has spread to the United States particularly through United Methodists. Their website defines a fresh expression church as follows: "a form of church for our changing culture, established primarily for the benefit of those who are not yet part of any church" (Fresh Expressions). During a New Room Conference in 2015,Travis Collins led a workshop on how to start a fresh expressions church. Collins handed out a

sheet of paper with a list of over twenty different fresh expression themes like canoeing, rock climbing, knitting or book clubs and shared how people were coming to know Jesus in the context of participating in their favorite activities.

Such a church can be found in, *Afterhours*, which is a community meant to provide “a service for people who wanted to go beyond talking and listening about Jesus to people who wanted *to be* Jesus” (Herships 124). *Afterhours* was started by Jerry Herships in Denver, Colorado with the hope that the “party” would continue even beyond an hour of worship. He wanted to invite his “nonreligious” friends to hang out, listen to rock music have a short message, pray for one another, and make lunches to be distributed in the park to the homeless. His vision unfolds from the story of the first miracle when Jesus turned water in wine after the wine at a wedding celebration had run out. Herships believes that Jesus was showing people that the kingdom of God is an ongoing party for us to experience in some way on earth with the expectation that the best is yet to come. The church met for three years in a church building knowing it did not fit the vision they had. One day, a bar gave them an opportunity to start meeting in their facility on a night when business was slow. The bar owner was perplexed by the idea of people drinking while they gathered as a church in his bar. The church started gathering on Sunday or Monday nights then the following day arrangements would be made to meet in a park to hand out the lunches, share communion, pray and hangout. Six years later there are several services a week and lunches are served everyday no matter the weather. Many people have wanted to label *Afterhours* as “an outreach or a “ministry” because of the connection with the “feeding the homeless” and “not being churchy

enough" (Herships 137). This is not a result of the "fresh expression" movement per say, but definitely a "fresh expression" of how a church was formed.

**House Church or Table Fellowship**

With a greater desire for community rather than attending large worship services of one hundred or more, some people have turned to house churches as a model of church in the twenty-first century. Those who confessed to be Christians gathered in homes in the first century as recorded in Acts 2:42 and 46: "they broke bread at home and ate their food with glad and generous hearts." House churches were mentioned several times in the New Testament: Archippus's house in Philemon 1:2, Prisca and Aquila's house gathered in 1 Corinthians 16:19, Nympha's house is mentioned in Colossians 4:15, Epanetus's house in Romans 16:5, Lydia in Acts 16:40 and John's house in Acts 12:12, and Gauis' house in Romans 16:3. It's probable that the early church had to meet in private dwellings, because of the persecution of Christians or scarcity of resources. There is something about table fellowship in these house gatherings that are of particular interest in this project.

Jesus' teaching moments were often around the table, including his command to remember and share the elements in the Last Supper. Ultimately the Last Supper is a remembrance of Christ's death and resurrection for the forgiveness of our sins. There are three distinct parts that Jesus did at the Last Supper, which he incorporated regularly at the table. He gave thanks; he broke bread (or divided it to share) and distributed the bread. Jesus set the example as if to implicate that in giving thanks, it changes one's heart to joy and receptivity. To break the bread (or whatever element is available to the culture) is a moment to recognize that the people sharing are a part of something bigger than

themselves; it is to participate in the church's commonness. Then to distribute the bread allows the individual to reach out beyond one's self-centeredness to another. Jesus Christ is the healer who brings wholeness to all. There is healing in each Christian when they serve or give of themselves. All churches recognize the sacrament of the Last Supper. However, in pursuing a Table Fellowship model of Church, the pattern is highlighted and participation in nourishing the body is central to the gathering.

Within each person is a desire for connection and identity. People seek out connection in their neighborhoods and in their workplaces. They identify themselves by what they do, where they live, by their favorite sports team or hobby. A person will not find satisfaction until they find themselves in relationship with God and one another. In Dustin Willis' book, *Life in Community: Joining Together to Display the Gospel*, he describes the lack of connection as follows:

> Too often we view our homes as places of refuge rather than tools to advance the gospel. My friend, Michael Rhodes stated, "Christians can be generous with their time and money, but stingy with their homes. We must repent from worshiping the comfort of our homes . . . Life will change for you when your home becomes a hub of hospitality rather than a home for the healed (Willis 150).

House churches are focused on sharing life and less on structure. The focus is not on preparing a worship service. There are practices of hospitality, fellowship, teaching and healing. When the people gather in a house church, there is sharing in the Word, Jesus Christ. As table fellowship develops and remembering who and what Christ has done for us worship is expressed from the heart. Worship is not a practice of the church, rather it is

"an obedient and sacrificial lifestyle: this sometimes involves singing, but only because the whole of life is living worship" (Simson 46).

On Lesslie Newbigin's website, he shares his vision on community that was taken from his book, *The Household of God*,

> It is surely a fact of inexhaustible significance that what our Lord left behind Him was not a book, nor a creed, nor a system of thought, nor a rule of life, but a visible community. He committed the entire work of salvation to that community. It was not that a community gathered round an idea, so that the idea was primary and the community secondary. It was that a community called together by the deliberate choice of the Lord Himself, and re-created in Him, gradually sought - and is seeking - to make explicit who He is and what He has done. The actual community is primary; the understanding of what it is comes second (Newbigin 20).

All people need to know that they matter; a house model or table fellowship model does this in a unique way. There is intimacy, vulnerability, and intentionality. At the table in a house church, Leonard Sweet encourages people "to come to the table to learn to be our real selves- not some construct conceived by someone else, but who God made us to be" (Sweet 45).

## Church Practices

Richard Foster, author of *Celebration of Discipline: The Path to Spiritual Growth*, wrote this book as a guideline on practices for Christians to use as tools for growing in their faith. There are twelve suggested practices; some focus inwardly, like prayer or meditation while some focus outwardly, like worship or service. He notes:

> The disciplines are God's way of getting us into the ground; they put us where he can work within us and transform us. By themselves the Spiritual Disciplines can do nothing; they can only get us to the place where something can be done. They are God's means of grace (Foster 7).

Of the practices listed in Foster's work, healing is not mentioned. Prayer is discussed as a constant means to commune with God but intercessory prayer is not a focus.

Spiritual gifts are listed in the scriptures as useful to "build up" the church (Eph. 4:11-13, 1 Cor. 12:28-30, Rom. 12:6-8). In *The Forgotten Ways,* Alan Hirsch suggests practices and gifts to be used by the church to fulfill the missional call, including the "APEPT" list from Ephesians for structuring leadership. The church is to be God's instrument in transforming lives more than giving people a "way of life." As a leader of South Melbourne Restoration Community in Australia, he and other leaders decided there were some core practices and spiritual disciplines that their houses churches (also called TEMPT groups) should implement (Hirsch 47).

| Core Practice | Spiritual Discipline |
|---|---|
| Together We Follow | Community or togetherness |
| Engagement with Scripture | Integrating scripture into our lives |
| Mission | Mission (central discipline-binding and integrating them) |
| Passion for Jesus | Worship and prayer |
| Transformation | Character development and accountability |

The TEMPT groups met weekly, and then several of the groups would meet twice a month. Any groups that where within a region met twice a year. In their assessments, they saw that the rhythms of their gathering and serving and sharing was an important part of transformation.

In, *Shaped by God's Heart,* Milfred Minatrea, a Baptist Pastor and Director of The Missional Church Center, shared the research of various missional churches which included the discovery of nine common practices among them. These practices are the bases for each of the chapters with the following themes: membership, authenticity, teaching vs. obedience, original worship, living out one's faith, follow through with purpose, measure metric as release rather than retaining, and prioritizing kingdom work. Minatrea does not intend for a missional church to utilize every one of these practices but he suggests any of these practices would be helpful in starting a new missional church with the intent to make a difference in the world. He suggests, "The church is what its members are (Minatrea xi)." This further affirms that missional churches are more focused on transformation that adding numbers of people simply learning "how" one should live.

**What is Mental Illness?**

Mental illness tends to be a term used in more acute or severe cases. Mental health conditions are also referred to as disorders in the DSM5 (The Diagnostic and Statistical Manual of Mental Disorders). A mental health condition may or may not keep a person from coping with life or being productive and active in their community. According to the website, MentalHealth.gov, mental health is defined:

> as our emotional, psychological, and social well-being. It affects how we think, feel, and act. Mental health is the ability to function effectively in daily activities, resulting in productivity at work and school, experiencing fulfilling relationships, and developing resilience to change and adversity. Mental health is important at every stage of life, from childhood and adolescents through adulthood.

According to NAMI (National Alliance of Mental Illness) a mental illness is "a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning" and "often result in diminished capacity for coping with the ordinary demands of life" (*Troubled Minds* Simpson 34). Six percent of the American population live with an acute mental illness like schizophrenia, depression, or bipolar (NAMI). The DSM5 (The Diagnostic and Statistical Manual of Mental Disorders) defines a mental disorder as:

> a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning (20).

Amy Simpson's book, *Troubled Minds: Mental Illness and the Church's Mission*, gives a glimpse of her life story as a Christian, a journalist, editor for GiftedForLeadership.com, a wife, a mother, a daughter of a mom with schizophrenia, and a preacher's kid to a dad that struggled with depression. Simpson and her sister found themselves trying to hide the fact that their mom had a mental illness during parts of their growing up. There were times she knew that the church had awareness of her mother's meltdowns but they did not do anything. Simpson noticed people would take casseroles to people with physical illnesses but no one brought her family one. She now refers to mental illness as the "no casserole" illness (*Troubled Minds* Simpson 33). The percentage of people who suffer with heart disease, cancer, HIV and AIDS and Diabetes combined is less than the number of people who live with a mental illness. However, most of those who have mental illness are not talking about it or seeing help because of the stigma or

misunderstanding of what can be done to help them (37). Simpson was empowered by *Leadership Journal* magazine to do a survey of five hundred churches to determine what people knew or did not know about mental illness. In her survey she found 12.5% of the church leaders said mental illness is spoken about openly. She found that 50% said that mental illness is talked about in sermons about three times a year, whereas 20% said it is never discussed in their church at all (53). There is a problem with stigma, lack of education about mental health and mental illness as well as shame that makes people want to hide it.

Rosemary Radford Ruether is a feminist theologian and professor of feminine theology at Pacific School of Religion whose son has struggled with mental illness, and the brokenness of the health care system in America. She is cautious about using the term, *the mentally ill*, when referring to a person, because she recognizes that this labels a person with a particular identity. This is part of the problem with the stigma in the American society. A person can be ostracized for “being mentally ill.” Rosemary Ruether says it is important to commit to being on a journey with people who are on the road to recovery rather than on a journey just “maintaining” them selves (Ruether 182). Over time, Ruether’s son has stayed at a variety of places one of which was called the MHA Village in California. This center developed four stages of recovery to lead a person with mental illness: hope, empowerment (giving opportunity and information), self-responsibility, and a meaningful role in life (172-174). These stages are similar to some of the discipleship stages Christians might use in churches.

Kathryn Greene-McCreight shares the story of her struggle with depression in her book and makes the following observation on the importance of Christian community:

> Sometimes you literally cannot make it on your own, and you need to borrow from the faith of those around you. Sometimes I cannot even recite the creed unless I am doing it in the context of worship, along with the body of Christ. Now, you could say that this is a fault of memory, and maybe it is in part, but I think it goes further than that. When reciting the creed, I borrow from the recitation of others. Companionship in the Lord Jesus is powerful (Green-McCreight 88).

Christian community matters to people with mental illness. Worship, prayer, and a sense of being united to "brothers" and "sisters" in the faith helps the troubled and the ill bear up under the weight of their heavy burdens. People may focus on getting person resources for "fixing" their mental health. Yet it seems that people like Kathryn suggest the need to develop community that includes worship, not just support or counseling services, it vital.

In the symptoms of certain mental illnesses or disorders "isolation" or inability to be involved with groups can be an issue. A person with mental illness or those who have family members with mental illness need to have the invitation to this bond between God and others in a faith community and may even need for the church to stand in the gap for them.

Referring to a statement by John Strauss, professor of psychiatry at Yale University, Swinton notes, "when one conceives of an individual who suffers from a mental health problem, one must think in terms of the individual as a person who also has a disorder, rather than a person who is a disorder" (*Resurrecting The Person* Swinton 137). From Swinton's perspective, Christians must never underestimate the importance of

friendship for people with mental illness. People with mental health problems are often experiencing “hopelessness, worthlessness, and poor self-esteem” (139). If a Christian have the courage to risk friendship with these suffering people in his or her midst, he or she has the opportunity to help them find hope and meaning. Swinton says,

> The model of friendship presented in the life and work of Christ offers real possibilities for therapeutic change. Committed friendship that reaches beyond culturally constructed barriers and false understandings and seeks to ‘resurrect the person’—who has become engulfed by their mental health problems—is a powerful form of relationship. It offers hope and new possibilities to people with the types of mental health problems that are the focus of this book (138–139).

The developing community of faith needs to be authentic and transparent. People need to see the church as a refuge where they are safe to say, “I need accountability and encouragement as I deal with addiction, brokenness in marriage or other relationships, mental illness or mental disorders.”

## How is the Culture Responding?

The culture is struggling with how to respond to people with mental health conditions and how to talk about their own. There have been a growing number of mass shootings in which conversations gravitate toward comments about the person who has committed the crimes being crazy. American leadership has made derogatory remarks about mental illness:

> In a tweet Thursday, President Donald Trump described someone who would shoot up a school as a "savage sicko." At CNN's town hall on the Parkland, Florida, school shootings on Wednesday, NRA spokeswoman Dana Loesch

> described the gunman as "an insane monster" who is "nuts" and crazy." And at a White House briefing Thursday, the President again used the term "sicko" (“*Trump’s Language on School Shooter’s Mental Health”* Christensen).

In studies documented by this article and others, Keisel stated that only four percent of interpersonal violence is related to serious mental illness. People living with a mental illness are ten times more likely to be victims of violence rather than commit a violent act (“*Don’t Blame Mass Shootings on Mental Health”* Keisel).

More and more there are plays, movies, songs, books, and websites addressing mental illness and mental health conditions. Sometimes these sources represent mental health correctly, and sometimes these mediums add to the misconceptions. Sometimes a politician, actress or a famous person from some of these arenas will step forward to tell their story; Selena Gomez and Mayim Bialik are two of those people. Gomez, a singer and actress, opened up to the public about her struggle with depression and anxiety as well as her hospitalization to get help in 2017 (wellandgood.com). As Gomez was working on her own healing, she brought her experience and struggle into being the executive producer of a television series called, *13 Reasons Why*, about why a girl committed suicide. Bialik is an actress and neuroscientist, who stars in the hit television comedy*, The Big Bang Theory.* Because Bialik has family that has struggled with mental illness, she is a passionate advocate to eliminate the sigma of mental illness. She has used her stardom as a platform to talk about mental illness with groups like NAMI (www.nami.org). Throughout the literature reviewed and the gathering of information from various websites, it has been determined that greatest thing one can to do to help people with mental illness is to educate people on the misconceptions, so the shame and

stigma can be eradicated. Hollywood and moviegoers have supported movies in recent years that address mental illness such as: *Silver Linings Playbook*, *Birdman, Polar Bear* or *Spotlight*. These movies can be used as a foundation for a conversation to help people know what is true of false as well as encourage people to find resources to get help.

Because history lays a foundation for the present, it is important to look into the past to discover how previous misperceptions might influence today's misconceptions. In the remaining paragraphs the work of theologians, government leaders, scientists, and advocates will be revealed. Great minds of theology like Augustine or Soren Kiekegaard and those of science like Sigmund Freud or William Wundt influenced the people of their day and as well as the culture of America in 2018.

In the late-1700s, the age of Enlightenment started moving an emphasis toward science and reason in people's quest for truth.  In the mid-1800s philosopher and theologian, Soren Kierkegaard, wrote about the nature of a person, their despair, their anxiousness and what is called the "unconscious." In the late 1880s atheist, Sigmund Freud, developed the theory around the psychoanalysis of the subconscious and made quite an impact on the world's thinking on mental health. Freud's work has influenced the world's perception that supernatural experiences saying that it can be explained by chemical and neurological activity in the brain. He introduced the idea that people who sought spiritual connection were actually lacking in emotional maturity or had a pathological disorder (Kehoe xxi). The debate has ensued ever since.

Nancy Kehoe, a nun as well as a trained psychiatrist, developed a therapy program at the psychiatric hospital where she worked with the intention of talking about religious beliefs even if they were not Christian. Kehoe found that the people in the

therapy group were receptive to the conversation about faith. She was concerned with Freud's approach. In the therapy program she developed, the people admitted feeling wounded due to the rejection of a church or being angry with God because they had a mental illness. It seems that people struggle more with God for letting illness happen than with the reality of God's existence. God did not cause mental illness; he created the world and the consequences of humanities repeated rebellion against God has created a domino effect for mental illness.

Both people of Christian faith and those in the field of psychology or psychiatry pursue the truth, but the basis for that truth may differ for each group. Christian faith is developed through Biblical and theological knowledge of the Triune God who cannot be seen except in revelation as God deems through the Spirit. Psychologists study behaviors in pursuit of empirical evidence based upon what can be proved. Psychology was established as a science in the mid to late 1800's after years of study on what Greek philosophers like Plato, Epicurus or Aristotle had developed. Writings about the soul and spirit by fathers of faith like Tertullian, Athanasius, and Augustine also impacted the foundation of this science (Johnson 10). It has been suggested that a man named William Wundt, started intentionally studying the human experience in a laboratory in 1879 (19). In "Psychology and Christianity: Five Views," it is suggested that the Bible offers a foundation for study of the mind although it is not "systematic or comprehensive" (11). Johnson's book goes on to share differing views on what psychology is and how various perspectives can be used to utilize the science for those with or without Christian faith. Theologian and Saint of the Church, Thomas Aquinas, combined the thoughts of Christian faith with theologian, Augustine, and a secular philosopher, Aristotle, with

remarkable results on psychological thought, the will, appetites, virtues, vices, habits, memory, intellect and emotions (12). There are many saints within the history of the church that are surprisingly considered among those who have written about this connection of Christianity and psychology, for example: Julian of Norwich, Thomas a Kempis and Bernard of Clairvaux. And then there are those who have come along since then to disregard faith. It seems that there has been a tension for a long time.

From time to time a person with passion brings attention to the needs in the culture and so it was in 1887 when a woman of great faith, Dorothea Dix, (1802-1887) led a crusade to advocate for those who suffered with mental illness (Ruether 146). In 1848, she went before the U.S. congress with a request for approval of five thousand acres in each state to be used for state funded hospitals for those with mental illness. Thirty-eight hospitals were established in twenty different states through her advocacy. Unfortunately, after her death, funding was limited so the people in these institutions were not properly treated. The vision of hospitals with grounds for farming activities and the resources for various other activities to help in treatments began to be eliminated. Needs for those with mental illness moved from the state to the national level under President Truman. In 1946 that Congress created The National Mental Health Act to develop research for mental illness (195). After WWII the effects of war propelled the idea of "community health centers" in what became known as "The Mental Retardation and Mental Health Centers Construction Act" in 1963 (155). There continued to be a shortage of funding and an increase in need. Continued development of plans for Medicare, Medicaid, Social Security and Disability Funding affected how much a person was given for care of any mental illness. In the 1980's many of the state hospitals for

people with mental illness were closed because the patients were in despicable situations. The multitude of homeless people on the streets or in prisons is due to the "deinstitutionalizing" of mental hospitals (Ruether 6).

Psychology, neurology and psychiatry are important in creating hope for people with mental illness whether the person is a Christian believer or not. While philosophers, theologians, innovators, spiritual leaders, and writers have pondered over how the mind works and its relationship to the human will, spirit and behaviors, there have been people living afraid of those who seem to not have control of themselves. This lack of control has been shown in people like those who would fall down with convulsions foaming at the mouth, run about naked in public while talking to themselves, watch people starve themselves, see people unable to pull themselves out of bed from a catatonic state or engage in a rampage harming others or himself or herself. The culture is looking for light on this subject. There is so much darkness and uncertainty.

**How is the Church Responding?**

Some churches are responding well, and some are not. While it is believed that people who suffer with mental illness need the skill of professional psychologists and counselors, it is also believed that ultimately wholeness comes in knowing and accepting in the Triune God who understands the suffering of the world as a Wounded Healer (Nouwen 82). Some churches respond to people with mental illness by over spiritualizing it and suggesting that a person needs to pray more. And then there is the other spectrum in which the church only mentions mental illness maybe one time a year or not at all. Mental illness affects those who follow Jesus and those that do not; it does not

discriminate. It affects a larger portion of our culture than any disease although it is not talked about as much ("*Mental Health and Public Health Interventions*" Andrade).

The researcher of this project reached out to Joe Padilla, director and cofounder of Mental Health Grace Alliance, to learn about the work being done by his organization to help Christians understand how to respond to mental illness. Padilla responded with an email and an attached link to a study done by Lifeway Research in the summer of 2014, spearheaded by Ed Stetzer, formerly the Executive Director of Lifeway Research, and funded partially by the organization, Focus on the Family. There were three surveys distributed in this Lifeway Research study to collect data: one incorporated to an audience of over one thousand Protestant pastors, another included three hundred thirty-five Protestant Americans who suffered from mental illness (both moderately and acute) and the third group included two hundred and seven Protestant family members who struggle with mental illness, but do not have mental illness themselves. Below is what was reported as the key findings from the Lifeway Research study:

- Few churches have plans to assist families affected by mental illness
- Few churches are staffed with a counselor skilled in mental illness
- There is a lack of training for leaders on how to recognize mental illness
- There is a need for churches to communicate to congregations about local mental health resources
- There is a stigma and culture of silence that leads to shame.

In an article, Ed Stetzer wrote for *Christian Counseling Today*, he comments,

> My challenge to the Church is that we might move beyond the whispering, the silence, the shame, and the stigma. Instead, let us understand and show others that Jesus came seeking, saving and serving the lost and broken around him (*The Church and Mental Illness* Stetzer 38).

In this same article, the Cofounder of Mental Health Grace Alliance, Dr. Matthew Stanford, is quoted, "the church's role in dealing with mental illness is to "relieve suffering, reveal Christ and restore lives" (38). There continues to be a need for the church to encourage "normalization" or acceptance of people with mental illness or mental health conditions. This study suggests that education and conversation need to be had to eliminate the silence and fear that has been prevalent for people affected by mental illness.

John Wesley was an advocate of providing for the poor, the hungry, the sick, and the uneducated. As a clergyman in the 1700's under the authority of the Anglican Church in England, Wesley who sought to provide food, education, medical care and shelter for those in need. He discovered that people with addictions needed "sanctifying grace" beyond just physical provision so he created what he called "penitent bands." In these groups of three to five, Wesley desired to stress to them the importance of depending on God and a community for support in leading a life worthy of the grace extended through Jesus Christ. Wesley understood the importance of accountability, encouragement, and development that comes with relationships that could be developed in three different size groups: societies, classes and bands. Eventually Wesley traveled to the United States with the intention of evangelizing Native Americans. However, in the midst of his witness that spread from England to the colonies of America, his piety and his theology, particularly on grace and free will, seemed to take root in the ears of the people. A movement gave birth to what is now a mainstream denomination called, The United Methodist Church. Wesley's model of church suggests taking the church to the streets to share the Gospel, to encourage dependence of God, accountability in community and support in recovery

from addiction is important. Wesley was a clergyman who set an example for the church to encourage community development even for people with mental illness.

Rosemary Radford Ruether believes there is a connection between spirituality and mental illness. She suggests, “Spirituality for the person with mental illness means not becoming overwhelmed by all that has been lost so that no one falls into suicidal depression. It means keep hope alive. It means starting every day with the sense that something new will happen” (Ruether 187). Ruether and others like Jean Vanier or John Swinton would suggest that people with mental illness need access to develop their spirituality in a community. They need more than scientific or medical approaches to their wellbeing. People with mental health conditions need holistic care.

## Research Design Literature

Key words like “church planting, church models and mental illness” were extracted from the purpose statement of this research project to be studied with a biblical, theological, and ecclesial lens. As a pre-intervention research project, the literature review has focused on the practices and dimensions of ministry for people affected by mental health conditions in the current churches and community organizations of Orlando. A mixed method approach is used in this project with quantitative and qualitative methods in order to have a rich measurable set of outcomes to solve the problem addressed in the purpose statement. Qualitative research is useful for interpreting and expressing the social aspects of this project. In accordance with qualitative researchers, the author is “most interested in how humans arrange themselves and their settings and how inhabitants of these settings make sense of their surroundings” (Sensing 57). Sensing warns that qualitative research can bring about a plethora of information that

can keep a researcher bogged down with information, however, the researcher of this project determined to use quantitative research to help keep balance in the project. Data triangulation will be used in the analysis of the quantitative methods obtained through surveys and the qualitative method obtained through questionnaires and interviews (85). The use of "triangulation (multiple data-collection technologies designed to measure a single concept or construct)" brought validity and clarity to the project (72). It will provide depth to collection and analysis of the data. The literature reviewed provided the information to create three research tools (surveys, questionnaires and unstructured interviews) to bring in three angles (researcher, insider-pastors, outsiders-mental health community organization leaders) needed to have a valid summation for this project. To report the data in the interviews, notes were taken, the conversations were audio-recorded and then both were combined and transcribed.

## Summary of Literature

There were valuable insights gleaned in all four-research theme categories: the Church, church planting, church models, church practices and mental illness. Each of these categories has been individually studied but will be integrated by the end of this project. There are four themes that have come through the research so far.

### The Church

There are people who are looking at the church and thinking about better ways to include and serve people affected by mental illness. The following is a list of suggested practices for the Church compiled from several sources. First, create churches that are intentional about creating friendships, support, and encouragement of people affected by mental illness. Second, create a culture of advocacy. Third, encourage learning about

mental illness and mental disorders to help alleviate the stigma. Fourth, offer support and empowerment to people affected by mental illness so it will not be considered the "no-casserole" illness. Fifth, show the people affected by mental illness that they are valued and accepted as people not as a mission project. And sixth, encourage people to tell their stories or include those stories in sermons, prayers, or times of testimonials.

**Church Planting**

Looking at how to plant churches, the first insight within "church planting" is the recognition that planting a church is not the goal; to reproduce disciples for Jesus Christ who reproduce disciples who reproduce disciples is the goal. That is to say, the new church model being created in this project is not for "a" church but for adding to the movement that Jesus already started so that multiplication happens again and again. To build a church for people to move from one church to another is not the point of church planting; the transformation of the Holy Spirit draws others to Christ and into discipleship. The second insight is that Biblical church planting is evangelism or proclamation of the Gospel that results in new churches. It is vital to seek a person or persons in the community who would be receptive to the Gospel that they become the catalyst for inviting people to be in the faith community. While sixty-eight percent of the population in the United States is churched, eighty-eight million are still unchurched (Garrison 160). There is a great need to plant more churches and to reach people in all the various walks of life which includes a quarter of the population who live with a mental illness. There are many ways to plant churches among the multitudes of the people of the world but the biblical model for new churches comes into existence as people come out of the kingdom of darkness and into the kingdom of light. (*Discovering Church Planting*

Payne Loc 1002). The third insight is that churches need to reflect the culture of where the church is growing. The church should be integrated into the peoples' lives instead of expecting people to enter into its doors to become homogenized. There is an incarnational and missional opportunity in this new distributing church model.

**Church Models**

In this category, various church models were discussed. In the following summary, a useful nugget that could be incorporated into a new church model is shown. First, the institutional model shows the importance of order and the importance of worship. Second, the focus on having a missionary mindset that takes the missional church into the community to proclaim the Gospel in word and deed recollects the call of being sent into the world. Third, the transparency and vulnerability of the recovery model is a reminder that Jesus calls all people even with mental health conditions to live in the truth and an expectation to progress in this life journey. The twelve steps used in recovery are really a discipleship strategy. Fourth, the fresh expressions model shows the importance of reflecting ones culture and reevaluating ones' posture. And finally, the house church encourages relationship and often includes teaching around table fellowship following the example of Christ who often taught at a table. There are elements within each of these models that could be beneficial in creating a church model that invites, and embraces people living with or affected by mental illness. In some ways, these models overlap and yet they are very different.

**Church Practices**

Churches that are firmly established often get set in their ways just as people do. Some of these churches offer a practice of practical help for people with mental illness

like: pastoral care, support groups (although mostly for addiction or for relational issues like divorce or grief in the loss of a loved one), food pantries, counseling centers (or referrals to counselors or doctors) or benevolent funds for things like rent or medical bills. These are all good things to do for people affected by mental illness. For this research project, there are practices that seem more helpful such as the practice of hospitality or compassion for inviting, the practice of welcoming and including, the practices of listening or serving that move a person to reach outside of themselves, the practices of healing and belonging that are part of a long term journey, and the practice of educating and advocating. With a culmination of all of these practices, Jean Vanier admits that there are blessings that he has received in friendship with people who have mental disabilities that he would not have had if he had surrendered to the invitation offered by God to serve and be in relationship with people who have mental disabilities.

**Mental Health Conditions**

The literature review has shown biblical, theological and secular considerations as to what mental illness or mental health conditions are or are not. John Swinton and Jean Vanier revealed differences between mental disabilities and mental illness in their writings. Books and articles written by Rosemary Ruether, Naomi Judd, and Amy Simpson gave personal accounts of what mental illness means to them and their families. Professionals in the field of mental health like Nancy Kehoe, a clinical instructor, and Susan Nathiel, a psychotherapist, were not as concerned about defining the terms but they gave insight into how people have tried to cope with mental illness their books. In the books by neuroscientist, Dr. Matthew Stanford, and the psychiatric professor, Dr. Harold Koenig, the connection of religion and science as they relate to mental health conditions

are addressed. Each author at least has the common theme that mental illness can be treated and each person is of value and dignity.

# CHAPTER 3

# RESEARCH METHODOLOGY FOR THE PROJECT

## Overview of the Chapter

This chapter takes this project from research done in the library to inquiry in real life by using specifically designed tools to survey and interview leaders in downtown Orlando. After the nature and purpose of the project is stated, specific connections will be made between the designed survey/questionnaire to the three research questions appropriated for this research project in order to show how these tools are both needed. The participants will be described and how they will be involved in this project will be discussed. Description of the designed instrumentation “RBB Survey/Questionnaire for Church Pastors/Leaders” and “RBB Survey/Questionnaire for Mental Health Community Organization Leaders” will be addressed as well as how it was distributed collected and analyzed (RBB are the initials for the researcher, Robyn Bradley Bishop). How the results of the instrumentation were handled in this part of this project will be presented in the closing of this chapter.

## Nature and Purpose of the Project

In this world people are living broken hearted over loss of relationships, loss of life, loss of dreams, loss of hope. There is hopelessness, because people do not know the message of hope and wholeness that is available through Jesus Christ by The Holy Spirit. One in five people live with a mental illness in a given year. Therefore, the entire American population is impacted. Many who struggle with mental illnesses are afraid to

tell others for fear of judgment or rejection, even by those who call themselves Christians. Whether intentional or subconsciously, judgmental words like crazy, looney or stupid are tossed about in Christian and secular circles to describe people that have mental illness (Ruether 103). When someone uses these types of words, a wall is erected between people who "have it all together" and those who are struggling or in recovery with mental illness. In Orlando, many churches have counseling services, and some have care ministries that support those with addiction, emotional wounds or other illness. The purpose of this project was to explore church models and community organizations that faithfully invite and include people with and affected by mental illness, in order to develop a new church model for downtown Orlando, Florida.

## Research Questions

### Research Question #1

What are the unique dimensions of ministry with people who have a mental health condition or with people who have family members affected by mental health conditions? This question was answered by the survey for community organizations in survey statements two and four as well as in the survey for church leaders in responses to the survey statements of numbers three and four. On the community leader questionnaire, questions two and four gave the leader an opportunity to give more detailed information than they could with rating the survey statements. On the church leader questionnaire, more detailed answers to this question were answered by responses on number two, three, five, six, and seven. In the interviews with the church leaders, the participants were asked what they do in ministry for people affected by mental illness. In the interviews with the

community organization leaders, they were asked what they see their church or other churches in Orlando that is beneficial for people affected by mental illness.

### Research Question #2

What is missing in downtown Orlando that would help people affected by mental health conditions? This question was answered by the survey for community organizations in statements three and six as well as in the survey for church leaders in statements five and six. On the community leader questionnaire, questions five and six gave the leader an opportunity to give more detailed information. On the church leader questionnaire, questions two, three, and seven gave more detailed information. In the eight interviews, the participants were asked what they think is needed in Orlando for people affected by mental illness.

### Research Question #3

What are some best practices for inviting and including people with or affected by mental health conditions in the context of a local church? This question was answered by the survey for community organizations in the responses of the first, second and fifth statements as well as in the survey for church leaders in all five statements. On the community leader questionnaire, questions two and six gave the leader an opportunity to give more detailed information. On the church leader questionnaire, questions two, three, and six gave more detailed information. In the interviews, the participants were asked how they include people affected by mental illness in their church and how they address the needs of this people group.

## Ministry Context for Observing the Phenomenon

This project had survey/questionnaires and interviews with leaders in churches and

community organizations in the Orlando area. The leaders who participated in this project came from a city that developed as "resort town" and was the center of the citrus industry starting around late 1875. Downtown Orlando is home to two sports teams, the National Basketball Association team, Orlando Magic, and the Major Soccer League team, The Orlando City. The people of Orlando tend to be open to new ideas and new ways of doing things. Hence, in 1971 the city became the home of the Walt Disney World Resort, which brings in approximately fifty million visitors yearly. It has been reported that the population of Orlando was two hundred seventy seven thousand people in 2016 and 2.13 million in population if you included the Greater Orlando metropolitan area (World Population Review). Forty-one percent of the population of Orlando is white, twenty-eight percent are African American and the remaining are of Hispanic, Asian, Native American of from another race (World Population Review). According to this World Population Review website, only six percent of the population are unemployed. The Gallup poll of 2015 results posted on the World Population Review website, shows that only thirty-two percent of the population attends church weekly and forty-five percent never attend church *("Florida Average for Church Attendance"* Barth). The city of Orlando website includes a map of downtown with a pin indicating various points of interest. There are twenty churches highlighted on the map, which include three major Christian denominational churches: First United Methodist Church, Downtown Baptist Church, and First Presbyterian Church (www.cityoforlando.net). There are also a host of businesses, restaurants, beauty salons, hotels, museums and more. Orlando is a thriving city.

## Participants to Be Sampled About the Phenomenon

### Criteria for Selection

With the intent to learn more about current church and community organization practices that address mental illness in some way, the researcher chose to explore the practices of twenty-seven churches and twenty-five community organizations that focus on mental health conditions in the Orlando area. At first the number was limited to only a dozen churches and a dozen community organizations. However, a larger group was chosen in case some of those chosen decided not to participate. Participation in this project was completely voluntary. Hoping to hear from the leadership in each of the churches or organizations listed, the researcher created a survey/questionnaire for one leader in each context. Because the topic of mental illness can trigger fear or sensitivity in adults, an age limit of being at least eighteen years of age was imposed. For this research project, the researcher asked only adults to share their reflections on the questionnaires in order to minimize any negative affects this project could have. The list of mental health community organization leaders and the list of church pastors/leaders in the downtown Orlando area was chosen by a simple "Google" search. The two lists are attached to this project in Appendixes E & F.

### Description of Participants

The instrumentation was administered to "leaders who work in Orlando in the mental health field as well as pastors or leaders in churches." The list of participants was derived from a Google search in two categories: churches in the downtown area, or community organizations that serve people with mental illness. Some of the people on the lists provided in Appendixes E and F were not found on a Google search but were given by

a participant or neighbor who lives downtown as a suggestion. The lists of those who would receive the surveys/questionnaires did not have any indication of their age, gender, education level, ethnicity, race, and etcetera in order to participate. While the city has a fifty percent population of Caucasians the researcher did not seek people of a particular race or ethnicity. The two common denominators for the participants in this project were first, employed in the Orlando area and second, willing to be a part of this research project as indicated by the completed consent forms. See Appendixes E & F.

**Ethical Considerations**

There are several considerations when working on a research project. This section of the project documents the details around administering the tools for this project and how the information was collected and reported. A consent form was prepared for each participant with particular elements regarding ethical considerations. For example, a participant could indicate if they wanted their name or their organization's name to be kept confidential on their survey, questionnaire, or interview. There was also a line on the consent form that gave the participant the opportunity to pull out of the project at any time for any reason. The completed research tools were kept in private, if the participant indicated they wanted confidentiality, as indicated to the Institutional Review Board of Asbury Theological Seminary. No one received any compensation for his or her participation in this project. No gifts were offered or suggested to anyone involved in this project. Some of the participants did indicate that they want to see the results of the final dissertation so that is the only thing that has been assured to participants.

## Instrumentation

### Expert Review

A formal letter was prepared for each of the four expert reviewers with details about the project. When each of the four received a copy of the two different survey/questionnaires, a codified table was included so the expert reviewers could give their feedback on what had been created. Changes were made at the suggestions of the reviewers and the researchers. The letter was personalized for each expert reviewer and details about the project were discussed by phone as needed. The interviews offered in this research project were given using questions from the survey/questionnaires.

### Reliability & Validity of Project Design

Upon review of the websites for all of churches and mental health community organizations in Orlando, as shown in Appendixes E and F, lists of potential participants were created. In order to fulfill the purpose of this research project, both qualitative and quantitative research was administered in the two different Survey/Questionnaires designed: "RBB Survey/Questionnaire for Church Pastors/Leaders" and "RBB Survey/Questionnaire for Mental Health Community Organization Leaders." Guidelines for how to develop a survey using a scale and an open ended questionnaire were used to create these instruments (Sensing 113-115). A multiple methods approach was developed to allow for greater reliability and validity of the research for this project.

Reliability is all about consistency. Research is reliable when it is consistently prepared, administered and analyzed. The surveys/questionnaires were not given under duress, but through email or delivered by hand to the participants so they could be filled out when he or she was able to fit it into his or her schedule. There was variation in how

the participants filled out the survey/questionnaires, but there was consistency in these tools as they accurately address the three major research questions, which address the purpose of the project. The church leadership interviews and the community organization leadership interviews were conducted with questions based upon the participants' answers on their survey/questionnaires, keeping with the consistency of the project's research plan of execution.

Validity of research is a term to indicate accuracy and the ability to fulfill the purpose this research project. The instruments were developed to address the purpose of this project and were administered to gather data that was accurate so as to answer the three research questions. It is probable that someone could repeat the research that was done for this project by following the procedures listed above.

**Data Collection**

This is a Pre-Intervention Project, which uses data triangulation with quantitative and qualitative research (Sensing 74). The researcher developed a list of twenty-seven churches and a list of twenty-five community organizations that address mental illness within the Orlando area. Two, separate survey/questionnaires, "RBB Mental Illness Survey/Questionnaire for Church Pastors/Leaders in Orlando," and the "RBB Mental Illness Survey/ Questionnaire for Community Organizations," were designed by the researcher along with an introduction letter and consent form. The introduction letter and consent form were developed from the IRB template. On the letters requesting participation, two options were given for returning the survey/questionnaires and consent forms: regular mail or email. If the participants did not respond within two weeks, the researcher called to follow up with them. "Data Collection begins with setting the

boundaries for the study; it continues by collecting information through observations, interviews, documents, and visual materials, etc., and concludes by establishing the protocol for recording the information" (Sensing 90).

Once each survey/questionnaire was received, they were separated into two categories: churches and community organizations. The questionnaires that came from a church were given a code that starts with "Ch" to indicate that they are a part of the "church" investigation list, then they were given a number starting with "1." The community organizations were given "CO" with a number. The Ch and CO leaders were coded for confidentiality. The information was kept private unless the participant indicated their permission for their name to be shared. All questionnaires will be destroyed at the completion of this and its approval in July 2018.

Not all fifty survey/questionnaires were completed and returned. The researcher also hoped to have the consent of at least twelve of the pastors or community leaders to have unstructured interviews. The interviews were recorded and notes were taken if the participant was willing. In light of privacy and convenience, interviews took place at a location chosen by the participant. The recordings were kept private when transcribing the interviews by using the coding system described above. All electronic files of the interviews and the questionnaires were kept in a password protected older on the researcher's computer.

## Data Analysis

In order to get conclusive answers to what and how the church is responding to people affected by mental health conditions, the surveys/questionnaires and interviews had the same topic asked in different ways. After collection of data from the quantitative

and qualitative methods, the data was analyzed to bring "order, structure, and meaning" (Sensing 194). For a thorough data analysis, the researcher adhered to the five step process suggested by John W. Creswell and J. David Creswell in their book, *Research Design: Qualitative, Quantitative, and Mixed Method Approaches* as indicated in the following description (Creswell and Creswell 193). First, organize and prepare (193). Second, read and review all of the data, which could include assessing what might be missing in the data (193). While looking at the information literally, interpretatively and reflexively, patterns were accessed in what was said or written as well is in what was not said or written (Sensing 196). Third, code the data by clumping data together (Creswell and Creswell 193). The coding themes for the project were assigned according the research themes related to the three major research questions: church planting (Cp), church model (Chm), mental illness (mi), mental health (mh), community organizations (CO), churches (C), practices (P), and dimensions of ministry (DM). Fourth, generate a description and separate the material in such a way that you may have five to seven themes (194). Fifth, represent a description that makes sense of the data and gives insights into the themes developed (195). This last step requires decisions to be made that show a developed framework of the data. Sensing suggests four ways to consider presenting your themes: processes, issues, questions and sensitizing concepts (Sensing 210). Chapter five will present the report of the analysis.

CHAPTER 4

# EVIDENCE FOR THE PROJECT

## Overview of the Chapter

In chapter three, the participants were described as well as the research tools. Within this chapter, the information collected from the tools designed for this project will be reported. Under the title of the three research questions each will have two categories: Church Pastors/Leaders and Community Organization Leaders. Within the information listed for each research question, there will be three additional subdivisions within these categories listed as: Survey Results, Questionnaire Results and Interview Results.

With a list of twenty-seven churches and a list of twenty-five community organizations in Orlando by a simple "Google" search for those in the downtown area of Orlando, the two lists were compiled (See Appendixes E and F). Each leader was sent a letter of introduction, a consent form, and a survey/questionnaire based on whether they were a leader in a church or a community organization. Each leader was given a code when they were sent these items, although their introductory letter was personalized for their eyes only. For example, a church leader was given the code, Ch3, and is referred to as Ch3 in the Tables of this chapter instead of by their name or organization name when their information was reported from their survey/questionnaire or interview in this project. In the table charts used within this chapter, the codes are not listed in chronological order like "1, 2, 3, 4," because not everyone chose to participate.

## Participants

Mental health can be a sensitive topic therefore the survey/questionnaires and interviews were only administered to adults. There were no particular characteristics or

attributes needed for participants in this project; however, the instrumentation was administered to those considered to be "leaders who work in downtown Orlando." The lists of those who received the surveys/questionnaires did not indicate the age, gender, education level, ethnicity, race, or any other description. However, there were two common denominators for the participants in this project, which will be reported under the two categories: community organization leaders and church pastors/leaders.

## Community Organization Leaders

**Table 4.1 Responses of the Twenty-Five Community Organization Leaders**

| Never Responded | 12 |
|---|---|
| Said, "YES," on phone, received Survey/ Questionnaire said, "NO, I can not do it at this time." | 6 |
| Closed their doors | 1 |
| Said, "Yes, if you become one of our counselors." | 1 |
| Said, "Yes" to Survey/Questionnaire | 5 |
| Said, "Yes" to Interview | 4 out of 5 who responded to Survey/Questionnaire |

Only sixteen percent from community organization leader list agreed to complete the survey/questionnaires designed for them. The researcher made phone calls to all of the people on the prepared list and sent emails per their request but due to busy schedules and other reasons, many leaders chose not to participate in this project. Some people said they could participate but after receiving the survey/questionnaire, they decided they could not. Within the organizations that responded, none of them were of the seven places that have residential facilities. Thirteen of the twenty-five organizations on the list are located within three miles of downtown Orlando. The one organization that closed their doors did so because of financial issues.

**Table 4.2 Demographics of Community Organization Leader Participants**

| Participant | Gender | Age Over 30 | Race | Role | Connected with a church | Orlando resident more than 3 years | They or a family member has mental illness |
|---|---|---|---|---|---|---|---|
| CO2 | Male | Yes | Caucasian | Director | Yes | Yes | Yes |
| CO13 | Male | Yes | Caucasian | Counselor | Yes | Yes | Yes |
| CO15 | Male | Yes | Caucasian | Counselor | Yes | Yes | No |
| CO20 | Male | Yes | Caucasian | Counselor | Yes | Yes | No |
| CO21 | Male | Yes | Caucasian | Counselor | Yes | Yes | Yes |

Four of the community organization leaders were willing to give an interview. All four participants have the following characteristics in common: male, white, connected with a church (although only two identified which church they were affiliated with) and they all four appeared to be over thirty years of age. Interviewees were counselors from mental health counseling organizations; one was a leader of an organization that advocates for mental health. Interviews were held at the office of the research participants for thirty to sixty minutes depending on the time the leader was available. Three out of the five indicated on their questionnaire that they have a mental illness or have a family member with a mental illness. All were dressed casually and allowed a recording of the conversations and notes.

## Church Pastors/Leaders

**Table 4.3 Responses of the Twenty-Seven Church Pastors/Leaders**

| | |
|---|---|
| No Response | 9 |
| Said, “No” to the Project | 6 |
| Said, “Yes” then pulled out of the Project once they received the survey/questionnaire | 1 |
| Missed each other’s calls/could not connect | 2 |
| Said, “Yes” to Survey/Questionnaire | 8 |
| Church number was disconnected | 2 |
| Said, “Yes” to Interview | 5 of the 8 who participated in the Survey/Questionnaire |

Thirty-two percent from the church pastor/leader list agreed to participate in this research project. Phone calls were made to all of the people on the prepared list and emails were sent when requested. Due to busy schedules and other reasons fifteen leaders chose not to participate in this project. The majority of the churches on the potential participant list were of the category, "non-denominational," with nine. The second highest denomination represented was United Methodist and Presbyterian with four responses per denomination. There was only one Catholic Church, one Disciples of Christ, one Episcopal and one Greek Orthodox. There may be house churches or other forms of church in Orlando, but they did not come up in the "Google" search.

**Table 4.4 Demographics of Church Pastors/Leader Participants**

| Participant | Gender | Age Over 30 | Race | Role | Ministry or counseling center at church | Orlando resident more than 3 years | They or a family member has mental illness |
|---|---|---|---|---|---|---|---|
| Ch1 | Female | Yes | Caucasian | Director | Yes | Yes | Yes |
| Ch3 | Male | Yes | Caucasian | Pastor | Yes | Yes | Yes |
| Ch4 | Male | Yes | ? | Director | Yes | ? | No |
| Ch8 | Male | Yes | Caucasian | Pastor | No | Yes | Yes |
| Ch15 | Male | Yes | Caucasian | Pastor | No | Yes | Yes |
| Ch17 | Female | Yes | Caucasian | Pastor | No | Yes | No |
| Ch19 | Male | ? | Caucasian | Pastor | No | No | No |
| Ch21 | Male | Yes | Caucasian | Pastor | No | No | Yes |

Five of the eight church leaders who participated in the survey/questionnaire were willing and able to give time for an interview, although due to scheduling conflicts two of them were unable to give an interview. We met at the office of the research participant for thirty to sixty minutes depending on the time the leader was available. All were dressed casually and allowed the recording of the conversation and notes. Out of the five interviewees, all were Caucasian, only two people were of female gender, and all of these church leaders were from churches within three miles of downtown Orlando. Although

there was never a request to know the age of the interviewees, it appeared that each one was over the age of thirty. Five out of the eight have a mental illness or a family member affected.

**Research Question #1: Description of Evidence**

What are the unique dimensions of ministry with people who have a mental health condition or with people who have family members affected by mental health conditions?

***Community Organization Leader Survey Results***

**Table 4.5 Responses of Community Organization Leaders to Survey Statement #2**
***"My church is doing a great job of teaching and serving people with or affected by mental illness."***

| 1<br>not at all | 2 | 3<br>somewhat agree | 4 | 5<br>completely agree |
|---|---|---|---|---|
| | | CO21 | CO13 | |
| | | CO2 | CO20 | |
| | | | CO15 | |

In response to this question, survey statement number two asked the participant to rate their response as shown in the table above with three being in the middle as "somewhat agreeing." As indicated each participant has a code. The responses of these leaders were separated into colors and organized according to the indicated statement for reporting the survey results. It appears in Figure 4.5 that all participants do not completely agree, although three out of five somewhat agree. This statement also acknowledges that all of the participants are connected to a church.

**Table 4.6 Responses of Community Organization Leaders to Survey Statement #4**
***"Ministry to people with mental illness is different than ministry to people without."***

| 1<br>not at all | 2 | 3<br>somewhat agree | 4 | 5<br>completely agree |
|---|---|---|---|---|
| | | CO21 | | CO13 |
| | | CO20 | | CO15 |
| | | CO2 | | |

In response to question #1, survey statement number four asked the community organization participant to rate their response as shown in the table above with three being in the middle as "somewhat agreeing." The responses of these leaders were separated into colors and organized in Table #4.6. Two out of five completely agree that ministry to people with mental illness is different.

**Table 4.7 Responses of Community Organization Leader Question #4 Results**
***"Do you think there are dimensions of ministry that are different with people affected by mental illness?***

| | | | | | |
|---|---|---|---|---|---|
| **Public worship** | | | | | **X** |
| **Pastoral counseling/ Counseling** | | **X** | **X** | | |
| **Depth of dysfunction** | **X** | | | | |
| **Normalization** | | | | **X** | |
| | **CO2** | **CO13** | **CO15** | **CO20** | **CO21** |

From the questionnaire, question number four addresses this research question. CO15 chose to reply to this question with NA (non applicable), because this leader does not participate in any "ministry" at a church. CO15 believes that counseling is their ministry. Instead of saying they agree or disagree, CO20 wrote: "I don't know," then went on to explain that they would like to see "mental health normalized into all areas." Only two out of the five participants wrote specific comments about the struggle between differentiating pastoral counseling with professional counseling.

Upon review of the information given it appears that something is missing in the answers to the survey/questionnaire. There does not seem to be any description of what is being done currently which could indicate that there isn't any ministry specifically done at the churches where they are connected according to these leaders.

After asking for a "yes," "no," or "maybe" in response to questionnaire research question one, CO2 implied in their written comments that the level of dysfunction (of a

person's mental health condition) is an important factor in ministry with people affected by mental illness. CO13 wrote about the higher level of commitment for pastors of churches with mental health ministry. CO13 also acknowledged that pastors need more education on how and when to refer people to counseling services versus doing all the therapy them selves. CO21 was the only participant who mentioned public worship as something to alter for people affected by mental health conditions. CO21 wrote: "Churches are typically public worship meetings that bring a natural aspect of social interaction and fellowship," (however) "for those with mental illness, this can be stigmatizing and produce social anxiety."

### *Community Organization Leader Interview Results*

A tenant of CO2's organization is that they seek to "see the person, not the illness." CO2 said in the interview:

> I would go back to, "Is ministry the same for someone with diabetes as for someone without diabetes. Roughly it is. I may say it's not completely the same, because you might have to say things in a different way. As a pastor, isn't that true for everybody? There are people who are getting something out of the sermon and then there are people who are counting the minutes until they get to go to brunch. Each person is going to need something different.

Overall, CO2 indicated that an organization has to do different things to reach different groups of people but the "overall message to everybody about forgiveness and grace is the same."

In the interview with CO13, it was stated:

> It is important not to label people. If I say to a person they are stupid then if I say it often enough they will believe it. A diagnosis is not always necessary except as it pertains to how to care for a person, to label a person. I believe we should always use the least obtrusive diagnosis as possible. And so you must be very careful to give diagnosis. You must be sure. They are recorded. It's like if you run a red light, you get a ticket. It stays on your record. All records stay for seven years. When I give a diagnosis it goes on record. I am required by law in the state of Florida to keep records for seven years. If I see you six and a half years from now then it's another seven years.

It was also important to CO13 to "recognize people's limitations, and difficulties regardless of what it is."

CO21 considered the response as to whether the church should be doing more to help people with mental illness, by saying: "That's tricky; I mean the churches that think it's a sin (to have mental illness), I don't think they should do more. I'd say do I want "the" church to do more about helping people with mental illness the way I want them to, then yes, I think they should do more." Therefore, it seems like perspective is important in this kind of ministry. Each one of those interviews indicated this as important. CO21 said that boundaries are important in this kind of ministry: "Knowing boundaries; knowing when to counsel them and when to know to send them off to someone who is trained." Whether a pastor or ministry leader or peer, to be educated on mental health is helpful for all involved in this ministry with people affected by mental health conditions.

No one mentioned support groups or twelve step programs as useful or not useful for people affected by mental health conditions. There was no connection made to the

twelve-step ministry called Celebrate Recovery and no one mentioned addiction. No one mentioned demon possession or homelessness as a dimension to be considered, even though both of these have been associated with mental illness in scripture as well as society at large. There was focus on counseling, but very little connection to "ministry."

### *Church Pastor/Leader Survey Results*

**Table 4.8 Responses of Church Pastor/Leaders to Survey Statement #3**
***"My church has the resources to serve people with or affected by mental illness."***

| 1<br>not at all | 2 | 3<br>somewhat agree | 4 | 5<br>completely agree |
|---|---|---|---|---|
| | Ch15 | Ch1 | Ch21 | Ch3 |
| | | Ch8 | | Ch4 |
| | | Ch19 | | Ch17 |

In response to question #1, survey statement number three on the Church Pastor/Leader Survey asked the participant to rate their response as shown in the table above, Table #4.8. The responses above indicate that half of the participants think they have adequate resources to minister to people with mental illness and the other half believe this to be true only somewhat or less than somewhat.

**Table 4.9 Responses of Church Pastor/Leaders to Survey Statement #4**
***"Ministry to people with mental illness is different than ministry to people without."***

| 1<br>not at all | 2 | 3<br>somewhat agree | 4 | 5<br>completely agree |
|---|---|---|---|---|
| | Ch2 | Ch3 | Ch1 | Ch8 |
| | | | Ch15 | Ch19 |
| | | | Ch17 | Ch21 |

In the above Table #4.9 it appears that three out of eight of the participants completely agree that there is a difference in ministry to people with mental illness. No one disagreed with this statement.

***Church Pastor/Leaders Questionnaire Results***

**Table 4.10 Responses of Church Pastor/Leaders to Question #5 Results**
***"What is different in ministry with people who have mental illness?"***

| | **Ch1** | **Ch3** | **Ch4** | **Ch8** | **Ch15** | **Ch17** | **Ch19** | **Ch21** |
|---|---|---|---|---|---|---|---|---|
| **Leader ratio/ preparation** | X | | | | | | | |
| **Socialization** | | X | | | X | | X | |
| **Expectations** | | X | | | | X | X | X |
| **Adaptability/ Flexibility** | X | X | | X | | X | | |
| **Tools** | | | X | | | | | |
| **Safety** | | | | | X | | | |

From the questionnaire for church leaders, question number five addressed this research question. Support groups were not mentioned in any of the answers to this question, but were referred to as an element that is helpful as a practice necessary for the church to have. Everyone's responses have similar themes. Four out of the eight participants indicated that adaptability and flexibility are important dimensions of ministry with people affected by mental illness. This theme includes: more sensitivity, more patience, more time, or more emotion. Ch17 said, "My conversations with and care for those with mental illness requires more patience- time, emotion- and recognition that the condition may be chronic." Four of the participants included a concern or at least the need to have recognition that the type of disorder or illness could affect expectations and socialization in ministry. For example, Ch15 said, "Some types of mental illness seem better understood. Some, such as (a person with) paranoid schizophrenia cause concern for safety among "normal" people. There are unusual affects and behaviors that are often difficult for "normal" people to understand." Ch19 is the only one who mentioned that medication, or the lack of medication, could affect the "socialization" or the ability to comprehend the Bible. Ch1 commented on the need to train leaders on how to deal with

various scenarios because they could "run into some situations they may not feel equipped to resolve." There was only one participant that mentioned that the goals are the same, but the tools to reach those goals are different. There was no explanation of what was meant by "tools" except by mention of "supportive environment."

***Church Leader Interview Results***

Upon hearing Ch1 tell the story of how and why they connected with "the mental health healing ministry" of the church where they served; it became apparent that Ch1 hit a crisis point that made them want to stop the cycle of poor decisions in their life so they went to the church. Ch1 said,

> I felt like maybe some people are sweet well meaning Christian people who tell me I should just pray and read my Bible and love Jesus and yet it's not working. I am still returning to my own vomit. What does that say about me? Am I just more broken that the normal human being? Have I made this decision too many times that it is impossible not to make it again?

Ch1 talked about the therapeutic approach combined with the concept of the twelve-step support group approach of Celebrate Recovery as bringing what was needed to make changes in life. For Ch1's church they felt it important to help people develop a way to tell a person's story to encourage people to see how God has been with them throughout their lives even with their mental health condition.

In the second interview, Ch3 shared,

> I am trying to normalize counseling, therapy, medication, all that. Like can we get over ourselves and recognize that we are all broken people. I am trying to normalize this. If people start to say, "Oh, we can't talk about that" or "Oh my,

> did you hear the pastor is seeing a counselor" I try to be real open and up front. If you feel depressed, you don't have to always feel like that. There just isn't any reason you can't go get help so you get better. I want to encourage them to see a professional. If you have cancer you don't stay home. No one does that. So if you have a struggle with some sort of mental health issue, let's talk about it.

In summary of this participant's responses in our conversation, leadership transparency and willingness to open conversation about mental health was a priority in the ministry of people affected by mental illness in this church. In addition, there is a list of professional resources kept up to date and utilized as well as an "unwritten" list of people who are willing to share their struggles, so a person can have a "relational connection."

In the third interview, Ch8 did not seem to think there is a differentiation in ministry with those affected by mental illness; however, Ch8 did talk about the importance of boundaries. Ch8 said: "Sometimes our compassion is real, but it doesn't necessarily help the person where they are. We can perpetuate the illness or the addiction if we don't think about the consequences."

**Research Question #2: Description of Evidence**

What is missing in downtown Orlando that would help for people affected by mental health conditions?

***Community Organization Leader Survey Results***

**Table 4.11 Response to Community Organization Leader Survey Statement #3**
***"There is more that can be done for people with mental illness in Orlando."***

| 1<br>not at all | 2 | 3<br>somewhat agree | 4 | 5<br>completely agree |
|---|---|---|---|---|
| | | | | CO2 |
| | | | | CO13 |
| | | | | CO15 |
| | | | | CO20 |
| | | | | CO21 |

Across the board, all five participants completely agree that more can be done for people with mental illness in Orlando.

**Table 4.12 Response to Community Organization Leader Survey Statement #5**
***"I would like to see churches do more for people with or affected by mental illness."***

| 1<br>not at all | 2 | 3<br>somewhat agree | 4 | 5<br>completely agree |
|---|---|---|---|---|
| | | | CO21 | CO2 |
| | | | | CO13 |
| | | | | CO15 |
| | | | | CO20 |

Four out of five participants completely agree that they want to see churches do more for people affected by mental illness.

**Table 4.13 Response to Community Organization Leader Survey Statement #6**
***"People in Orlando talk openly about mental illness."***

| 1<br>not at all | 2 | 3<br>somewhat agree | 4 | 5<br>completely agree |
|---|---|---|---|---|
| CO15 | CO21 | CO2 | | |
| | | CO13 | | |
| | | CO20 | | |

In Table #4.12, the majority of the participants revealed that they only somewhat agree that people in Orlando talk openly about mental illness.

***Community Organization Leader Questionnaire Results***

**Table 4.14 Responses of Community Organization Leader Question #5 Results**
***"Do you think more is needed to be done in the Orlando area to help people with or affected by mental illness?"***

| | | | | | |
|---|---|---|---|---|---|
| **Financial support** | | | | **X** | |
| **Education** | **X** | **X** | **X** | | **X** |
| **Advocacy efforts** | | | | **X** | |
| **Normalization** | | | | | **X** |
| **Counseling services/opportunity for care** | **X** | | **X** | | |
| **Prevention services** | | | **X** | | |
| | **CO2** | **CO13** | **CO15** | **CO20** | **CO21** |

From the questionnaire, question number five addresses this research question. All five participants agreed that there is more to do in Orlando for people affected by mental health conditions. As indicated in the chart above, four out of five made comments on the need for more education. Two of the five participants noted the need for more opportunities like prevention and particularly those who do not have the financial means to get counseling.

Question six asked about the ways the participants were addressing mental illness in Orlando. It was also suggested by CO2 that institutions should "speak out about mental health conditions, because one in five people are living with a mental health condition." In response to question number five, CO13 wrote,

> Pastors need to know when and to whom to refer people to get counseling. Because counseling and any sort of treatment for mental health can be expensive, it was also suggested the need for more advocacy efforts to persuade policy makers to create better funding in Florida for people in need.

The fact that pastors are often used as counselors because of the expense of going to a counselor was noted as an issue that needed to be recognized. These comments explain why there is a claim in the chart above that there is a lack of financial support.

The participants do not mention "community" as an important. The need for education seems important across the board, but a place of inclusion or belonging was never mentioned. People's perspective on the topic and how it is dealt with seems to be the priority.

***Community Organization Leader Interview Results***

CO20 said that their counseling organization had received phone calls from the west side of Orlando requesting counseling services, so they researched that side of town and found that there was a need to open a counseling office. So they did. As the conversation began to discuss the Pulse Shooting that happened in June 2016; in their view the city responded well to the tragedy and the mental health needs of everyone involved. When CO20 expanded on answers given in the questionnaire regarding what was needed, CO20 said,

> I am not on the cutting edge generationally any more. I feel like someone younger could do something like on social media. In most counseling centers that I am aware of, at least the ones that are faith based, they have a web presence. Type in the key words and I think you will find help. I think Orlando is a fairly solid city in that way. It would be nice in terms of the public. Because of the ethnic populations, I think some ethnicity, are more hesitant than others to seek counseling. I think the African American community is a little more hesitant to seek counseling. The Latino community is a little more hesitant as well.

This was the only person interviewed, including the Church leaders who mentioned the fact that there are different ethnicities in downtown Orlando and how they tend to be hesitant to seek help for mental health conditions. CO13 stated: "I think

education is key. I also refer people to AA (Alcoholic Anonymous). Even clients that have narcotic problems I refer sometimes. They find AA is much more effective for them. An alcoholic will always an alcoholic. They need support."

**Table 4.15 Response to Church Pastor/Leader Survey Statement #5**
***"I would like to see my church do more for people with or affected by mental health illness."***

| 1<br>not at all | 2 | 3<br>somewhat agree | 4 | 5<br>completely agree |
|---|---|---|---|---|
| | Ch3 | Ch17 | Ch4 | Ch1 |
| | | Ch19 | | Ch8 |
| | | | | Ch15 |
| | | | | Ch21 |

Fifty percent of the participants completely agree that they would like to see their church do more for people affected by mental illness.

**Table 4.16 Response to Church Pastor/Leader Survey Statement #6**
***"People in Orlando talk openly about mental illness."***

| 1<br>not at all | 2 | 3<br>somewhat agree | 4 | 5<br>completely agree |
|---|---|---|---|---|
| Ch1 | Ch15 | Ch3 | | Ch4 |
| | | Ch19 | | Ch8 |
| | | Ch21 | | |
| | | Ch17 | | |

Fifty percent of the participants somewhat agree that people in Orlando talk openly about mental illness; twenty five percent of the participants completely agree. Only one of eight does not think people talk openly about mental illness in Orlando

*Church Leader Questionnaire Results*

**Table 4.17 Response to Church Pastor/Leader Question #7**
***"What is missing in the Orlando area to help people with or affected by mental illness?"***

| | Ch1 | Ch3 | Ch4 | Ch8 | Ch15 | Ch17 | Ch19 | Ch21 |
|---|---|---|---|---|---|---|---|---|
| **Community** | X | | | | | | | |
| **Leisure** | X | | | | | | | |
| **Opportunity for care for poor & underinsured** | | X | | | | | | |
| **Low barrier housing/homeless care** | | | | X | | | X | |
| **More psychiatric care** | | | | | X | | | |
| **Seminar/workshops** | | | X | | | | | |

From the church leader questionnaire, question number seven addresses this research question. Ch17 was the only participant who chose not to address this question. Ch21 commented that they were too new to the area to really know what is needed and Ch15 said they didn't know except that their spouse had trouble finding a psychiatrist. Ch1 is the only person who recognized lack of opportunity for some people with mental illness to connect; it was suggested in their answer to question seven that it might be a good idea to have "a safe place to hang out." Ch3 was the only one who voiced concern for the poor and underinsured in their written comments. Ch8 mentioned the need for short-term and long-term housing. Ch4 suggested the need for more seminars and workshops so churches would be empowered, but no one else talked about education. Both Ch8 and Ch19 made a connection between mental illness and homelessness; they both see the need for better public policy and provision for housing.

In the questionnaires, no one mentioned education as something missing or needed. Even though all eight of the participants agreed that the church has a responsibility to educate people about mental illness none of them mentioned it. I noted

that four out of the five community organization leaders did mention that education was missing in Orlando.

### ***Church Leader Interview Results***

As I mentioned in the results of the church leader questionnaires, Ch1 has a concern for people with more severe mental illness to have a place to go so they feel a connection with other people. Ch1 said,

> For people with more severe cases of mental illness, like we have a few people with more severe mental health issues; like one guy who has been coming to our "healing mental health ministry" is schizophrenic. We just have a smattering of people who are not going to find success under the type of structure that we do in our "healing mental health ministry" in terms of doing deep story work. They are doing what they can do by just sitting in on a sixty-minute meeting by just being present. I think finding a safe place for people like that to be fed and still have community is important yet there is a tension because you want to destigmatize it but you don't want there to be a distraction for those who want to walk through this process.

The church where Ch1 serves values relational connections and sees that as important need in the city of Orlando.

Ch3 talked about normalizing the conversation but recognized that in some cases people need more professional care than what they have at the church. Keeping a current list of resources for people with mental illness and setting aside funding for people in crisis is important to Ch3. In response to the Pulse tragedy, Ch3's church immediately

created a $20,000 fund so that any of the professionals who were impacted by the trauma of the event could get counseling. Ch3 said,

> We have several nurses and first responders involved in patient care that are a part of our church. Some were there for twenty hours straight. They saw things they had never seen before in their life. That's when we set up a $20,000 first responder fund for counseling for anyone who needs it. We sent that to the chief of police and said, "Hey, anyone who needs counseling can come to us and we will get them counseling for free." A number have taken advantage of that. We have had health care professionals who have taken advantage of it.

Ch3 believes it is important to keep an hear open to what is going on in the community and seeks to responded with support as needed.

Ch8 shared a story of involvement with people affected by the Pulse tragedy,

We have been very involved in the post pulse situation. We have had eight or ten families. Not sure quite how many but several were here that Monday of the pulse shooting. We had made arrangements for our care teams and our ministers to be here to be available. We had enough knowledge that we had grief counselors from one of the LGBT centers. We knew our boundary of what we could do. We knew we could be there for them and let them know we love them and we care for them. But in terms of grief management our response is gonna be, "we can be with you, we can love you, we can include you and we can help you." If you feel like you need something more than that. We don't have a mental health counselor on staff but we do have counselors that we contract with. That's how we approach things.

The church where Ch8 serves seeks to known in Orlando as a church that accepts and loves everyone.

**Research Question #3: Description of Evidence**

What are some best practices for inviting and including people with or affected by mental health conditions in the context of a local church?

***Community Organization Leader Survey Results***

**Table 4.18 Response to Church Pastor/Leader Survey Statement #1**
***"The church has a responsibility to talk about and educate people on the topic of mental illness."***

| 1<br>not at all | 2 | 3<br>somewhat agree | 4 | 5<br>completely agree |
|---|---|---|---|---|
| | | Ch1 | Ch15 | Ch3 |
| | | Ch4 | | Ch8 |
| | | | | Ch19 |
| | | | | Ch21 |
| | | | | Ch21 |

Sixty-two percent of the participants completely agree that the church has the responsibility to educate people on mental illness; no participants disagreed with the statement.

**Table 4.19 Response to Church Pastor/Leader Survey Statement #2**
***"My church is doing a great job of teaching and serving people with or affected by mental illness."***

| 1<br>not at all | 2 | 3<br>somewhat agree | 4 | 5<br>completely agree |
|---|---|---|---|---|
| | Ch1 | Ch8 | Ch3 | |
| | Ch15 | Ch21 | Ch4 | |
| | Ch19 | Ch17 | | |

None of the participants would completely agree that their church is doing a great job of teaching and supporting people affected by mental illness. Seventy-five percent of the participants somewhat agree or even less.

***Community Organization Leader Questionnaire Results***

**Table 4.20 Response to Church Pastor/Leader Question #2**
**"What specific ways has your church addressed the subject of mental illness within the past year?"**

| | | | | | |
|---|---|---|---|---|---|
| **Financial support** | **X** | | | | |
| **Educational seminars/normalization** | **X** | | | | |
| **Specified ministry** | | **X** | | | |
| **Community center/Opportunity for care** | **X** | **X** | **X** | **X** | **X** |
| **Atmosphere: welcome & safe** | | **X** | | **X** | |
| **Christian precepts: forgiveness, acceptance** | | | | **X** | |
| | **CO2** | **CO13** | **CO15** | **CO20** | **CO21** |

From the questionnaire, question number two addresses this research question. All five participants who completed their survey/questionnaires agreed in their answers to question number two that there is a great opportunity to do more to invite and include people affected by mental health conditions in the local church. In the chart above it was suggested not just to have support groups or educational seminars, but practices of hospitality to create welcoming and safe spaces. Overwhelmingly this chart shows that all of the participants see a need for the church to be a place that provides opportunity for care for people with mental health issues.

CO13 shared that the church where CO13 attends has a Sunday school class specifically for "special education" people, which has systems in place to protect against sexual predators. In other words, this ministry helps people with mental health disabilities and, at the same time, sees the need to be aware of how inclusion of people with some mental health conditions could create a problem if they have a sexual perversion, addiction or expression that could do more harm. In the answer given by CO21, it was noted that they did not know if the dimensions of ministry were different, because they "would like to see mental health normalized." This could seem contradictory to the statement made by participant CO13. CO15 wrote about the need for the church to reflect

the community it is in. CO20 stated that the church should provide outreach that should include "overall health and mental health." CO20 gave lengthiest answer to question number two by saying,

> Churches need to always provide a welcoming atmosphere to visitors and quests and break down stigma in any way possible. The Christian precepts of forgiveness and acceptance need to permeate through the church, providing a safe home for anyone to feel welcome.

### ***Community Organization Leader Interview Results***

CO20 revealed how their organization is involved in seminars held at a local church. CO20 commented on these seminars by sharing: "Two of our counselors from here are going to talk about "taking your emotional temperature" and then in the following week "depression" and the last week on "anxiety." So we are just saying, "Ok, here is where many of us live. Let's normalize this discussion and what it looks like. This is how we deal with it ourselves and also with whom we serve and who we relate to." CO20 also said that they know of three churches in Orlando that are doing things for people with mental health conditions by holding support groups or ministries like "Celebrate Recovery" from Saddleback or even having counseling centers. When asked what the church should be doing, CO13 said,

> I think every church should examine them selves to look at the programs and ask what (programs) are really necessary for us? I think many times we go off on a tangent. One time someone when off on a different trail like one time someone decided that the church needed to have a bar-b-queue pit that could be pulled by a truck. So we went out and spent three or four thousand then it ended up getting

> stolen. I think the church needs to focus on the children then the parents will come. The children are the future of the faith. Jesus said, “Suffer the little children and bring them unto me.” I believe you really need to have a very active children’s ministry.

CO2 shared a story about a pastor at a mega church who spoke publicly a couple years ago his struggle with depression. CO2 said this pastor is “the poster child” for what pastors and churches need to do to set the example for all of us to be vulnerable, transparent and willing to create conversation about mental health conditions. CO2 said another practice of churches that is helpful comes in the form of support groups like “Alanon or Narcanon.” CO2 said,

> Another way is a holistic approach, which sounds like what you are trying to plan. It’s health and wellness day on Saturday at Macedonia Baptist Church in Eatonville, which is a black church. Oh, my gosh. There is something there every Saturday whether it’s a seminar on mental illness, or health or finances. It’s not you just come here every Sunday morning; we give you your church inoculation then you’re gone for the week. It’s an overall approach of how we can help you here. There is something going on there all the time. It’s an overall approach to be that pillar of entry point.

And finally, CO2 said that the practice of reaching out and welcoming people of all kinds is important; inclusion is a practice.

CO21 made comments that mental health is not something that needs to be “fixed.” It needs to be addressed and then seen as a part of life. CO21 said,

> Studying in Switzerland, I can tell you that in Switzerland in the culture mental illness is thought of as basic hygiene. If you were to see somebody that is not taking care of them selves, you would wonder why that is and look for a way to help them to take care of themselves. Especially if you care about them, if you see they haven't had a shower in two weeks so you may say, "Hey look, you need to take a shower on a regular basis!" This may not be a good example, but there is this way of thinking that there must be something seriously wrong medically if you are not doing these things to take of yourself that is essential. So that's why it seems they use a medical model. Insurance pays for psychologists to make very good money there; they are expected to be very highly trained. They don't have a masters level counselor there. In the United States people who get a masters get this sixty-hour degree, but in Switzerland, it's a ninety-six hour degree. It's about the equivalent of a science degree. It appears that people really seek a balance in religious life, work life and leisure.

CO21 then gave a story about how a church has asked for CO21 to partner to help with educating people on mental health. It seems there is a larger disconnect in the US versus Switzerland.

### *Church Leader Questionnaire Results*

**Table 4.21 Response to Church Pastor/Leader Question #6**
***"What are the best practices your church uses to invite and include people with or impacted by mental illness in the life of your church?"***

| | Ch1 | Ch3 | Ch4 | Ch8 | Ch15 | Ch17 | Ch19 | Ch21 |
|---|---|---|---|---|---|---|---|---|
| **Leadership involvement** | X | | | | | | | |
| **Educational seminar** | X | | | | | | | |
| **Hospital-attending needs** | | | | X | X | | X | |
| **Normalization/dialogue** | | X | X | X | | X | | |

From the church leader questionnaire, question number six addresses this research question. Ch21 was the only one who wrote, “None at this time” in response to this question, although Ch17 said that church had little “intentionality in this area.” Through the efforts of a social worker the church of Ch17 learned how to respond to a boy in their church with a mental disability so they are more open to others with mental disabilities as a result. Hospitality and normalization are the two practices that are seen as most valuable in ministry that includes people affected by mental illness. The participants in their descriptions of being hospitable used the following terms: inviting, welcoming, connecting, and conversing. Ch4 said this about normalizing: “I believe we offer helpful resources that maintain Christ-centered focus, while not shaming or marginalizing an individual because of their illness.” Each participant gives a short list on what practices they have for this ministry, but each is a little different. Ch17 acknowledges the important of being personal in their connections and Ch19 mentions the importance of follow up. Ch3 and Ch1 indicated the importance of leadership involvement. According to Ch1 education is important so the church holds seminars and offers personal invitations to be involved in their “healing mental health ministry.”

***Church Leader Interview Results***

Ch1 told me that they believe there are several practices they do as a church to invite and include people affected by mental health conditions. Ch1 said they hold a series of ninety-minute seminars on three consecutive Mondays each July to educate people on mental health topics such as: anxiety, depression and emotional healing. Additionally, each September there is a Sunday that is totally focused on teaching people

about mental health conditions and they make an invitation for their weekly "group" ministry for people affected by mental health conditions.

Ch8 stated that their church wanted to make sure of the following: "You are welcome and you are loved. We will deal with you as a human being created by God. If you identify or need resources, we will help you find the resources that you need. If you have trouble to get the care that you identify that you think you need or want then we will help you as best we can. I think that is the church's role really." In the opinion of Ch4 "we should not focus on the illness. But we (the church) should be welcoming and supportive of those with illnesses."

## Summary of Major Findings

A lot of information was collected through the literature review; study of scripture, and in the data collected from the research tools designed for this project. The findings are as follows:

- People with or affected by a mental health conditions need to feel like they have belonging in a community, not just inclusion, so they can grow in faith without being relegated to life in the margins.
- Because the scriptures tell the Church to be a voice for the voiceless, Christians have a responsibility to advocate for people affected by mental health conditions through education and being educated so the church can effectively serve people in our communities.
- Involvement in the life of a church should include discipleship and leadership even in the midst of brokenness and weakness of physical, mental or emotional illness.

- There should be a blending of church models in the development of a new church model for people with or affected by mental health conditions.
- The practice of healing would be useful when developing ministry with and for those affected by mental health conditions.

# CHAPTER 5

# LEARNING REPORT FOR THE PROJECT

## Overview of the Chapter

This research project has sought to explore the practices of churches and community organization in order to assess what should be incorporated into a church model that is intentional about inviting and including people with or affected by mental health conditions. Thus far, five major findings have been reached. First, people with or affected by a mental health conditions need belonging in a community, not just inclusion, so they grow in faith without being relegated to life in the margins. Second, because the scriptures tell Christians to be a voice for the voiceless, the Church has a responsibility to advocate for people affected by mental health conditions through education and being educated so the Church can effectively serve people in every community. Third, involvement in the life of a church should include discipleship and leadership even in the midst of brokenness or weakness of physical, mental or emotional illness. Fourth, there is not a cookie cutter way to develop a church or ministry for people with mental health conditions. However, blending aspects of the church models studied would be useful in creating a new model. The practice of healing would be useful for a church developing ministry with and for those affected by mental health conditions. These five findings will be expounded upon in this chapter.

# Major Findings

## First Finding-Belonging, Not Just Inclusion

People with or affected by a mental health conditions need to feel like they have belonging in a community, not just inclusion, so they can grow in faith without being relegated to life in the margins.

## Personal Observation

At the onset of this project, it was assumed that people affected by mental illness needed inclusion in a faith community and were sometimes pushed to the margins of their faith community. As stated in the reasons why this project was important to pursue, I shared that people whom I knew personally and people who were in church families where I had served had shared with me their fear of telling others of their struggles with addiction or a mental health condition because they were afraid of how others would perceive them even in the church. Some people I spoke with felt like their AA group (Alcoholic Anonymous) or their Al-Anon (Co-dependent) programs were more like a church than the church where they attended because they felt included as a part of a community with all their flaws. They felt like they were connected in these groups in a way they could not be in their churches.

Prior to this project, I visited or learned about three different faith communities with a focus on the people group mentioned earlier in this project. The first faith community was Mercy Street, birthed out of Chapelwood, in Houston, Texas. The second was Jacob’s Well birthed out of Christ Church in Memphis, Tennessee. Third was the Celebrate Recovery community developed at Saddleback Church in southern California.

When I attended a worship service at Mercy Street, I recognized some similarities in how people where participating throughout the service like in an AA meeting. Everyone was invited to participate in the service; some would share out loud if they were celebrating a milestone like being in recovery of an addiction or they would share a prayer request if they were going to court to seek custody of their kids. It became evident to me that people involved in this community felt like they belonged to something bigger than themselves.

As mentioned in the autobiographical statement of chapter one, part of my call to be involved in this research project was related to the testimony of Jamey Lee who became a pastor and then started a faith community in Memphis, Tennessee based on the Twelve Step Recovery format. I never participated in the life of Jacob's Well, but I learned a great deal through their founder, Jamey Lee in phone conversations and emails.

The third church that I include here was the Celebrate Recovery ministry within Saddleback in Southern California. They created a Twelve Step ministry based on Scripture and then offered the nuts and bolts of the ministry so other churches could have their own. I did not attend a Celebrate Recovery service prior to this project, but I had read about this ministry online and talked to them about starting a Celebrate Recovery Model at the church where I was serving at the time. Celebrate Recovery taught me the importance of celebrating the progression on one's faith journey even with hang ups, woundedness or addiction.

In all three of the above experiences, it seemed like these faith communities were actually ministries within a larger Church. All three were primarily focused on addiction although they somewhat acknowledged emotional wounds or destructive habits. The

larger churches of these ministries offered support like prayer, finances, staff assistance and other resources to these ministries, but technically the people within these ministries were an entity of ministry of the larger church and this perplexed me. The focus in these three ministries was about creating a safe space for vulnerability, healing and building relationships with Jesus as well as one another and yet they seem to live in the margins of the church.

During this project, I participated in ministry offerings for people with a mental illness at various churches in order to have an experiential reference point instead of just having an intellectual concept within downtown Orlando. I attended three evenings of the Celebrate Recovery ministry at a Baptist Church in Orlando and found myself wondering how a person who does not know anything about faith would feel attending. I felt the religiosity of it. I also attended worship services at another church in downtown Orlando a few times, because I knew they had a ministry similar to Celebrate Recovery. I learned that they had developed a new model, ReGroup, for reaching people with mental health conditions. Through the influence of Dan Allender, this ministry was started and continues to encourage people to claim the story of how God has been at work in their life as well as surrendering the work that needs to still be done. Both of these ministries have impacted numerous people and continue to do so. I spoke extensively with the leader of ReGroup who shared with me that the church makes an intentional effort to make people who struggle with mental illness to feel included and valued. These churches speak from the pulpit about the need to get professional help if you are struggling and the need to get into a support group to find companionship for the journey. They offer education on symptoms of various mental health conditions through various

ways. So, in my research I have found two churches in Orlando that seem to be invitational and inclusive.

As stated in this finding, the need for inclusion or companionship in a community is not a new concept. The information in the surveys, questionnaires and interviews, reveals a tendency to compartmentalize people living with or affected by mental illness even if unintentionally. In some cases, the way programs, support groups, or ministries are set up, brings marginalization. They may be included but not necessarily embraced in relationship or called into leadership or service. In a phone conversation with author Amy Simpson, I asked her to consider what comes to mind when she thinks of an inclusive church. She noted that there are care ministries at her church, and she listed various churches with care ministries in her book. It became apparent to her that their efforts to be inclusive by having support groups and gatherings on a particular night there was something not quite right. Amy's response was this:

> My fear is that the message we are sending is this: "when people with problems come to church they should come on Monday nights when the people with problems get together. The implication is that the rest of us don't have problems." If you are not pulling people in then, we are marginalizing them to be people with mental illness whom we serve. There are multiple reasons this is important to recognize. It's as if we are saying people with mental illness are the only needy ones and maybe they're not as capable. Actually, everyone has something to deal with- nowhere is that more true than the church. Mental health does not catch God off guard.

Her comments confirmed what I had heard from various people, including what I was hearing in some of the responses from participants in this project. Amy went on to say that all people are given gifts, even people with mental health conditions. Many churches tend to suggest that a person get "their life" fixed so they can be involved in the life of the church or maybe even be a leader. There was no mention of discipling or equipping people with mental health conditions for leadership. I know there are people on boards or serving as pastors who are on medication for bipolar, depression, and anxiety. For the most part they keep it private because of shame and stigma. Creating relationships where people feel they belong means they are valued and heard; they would be missed if they were not there.

When we talk about "belonging" or walking along side someone who might be in crisis or even has a chronic struggle with their mental health, it should be noted that this person does not need to have their life "fixed" by their friend or companion. To build relationship means you walk with them as they have discovery, offering love and hope. In one of the interviews a church leader shared the following perspective:

> One of the things that I found most helpful that a counselor said when I was at a seminar on anxiety and depression was, "For the most part when we rush in to try to solve someone else's anxiety or depression by trying to tell them God has a plan, or everything happens for a reason, or any of those insensitive things that people try to say when someone is struggling. It's not that we want to alleviate their discomfort, but that we want to alleviate ours because it makes us just as uncomfortable to sit in a moment with someone who is struggling with anxiety and depression, because we don't know what to do and we don't know how to fix

> it." He said that's actually one of the best things you can do for someone struggling with anxiety and depression is just to sit there with them in that helplessness, because that is the closest place of empathy, because they feel a sense of helplessness. There is not easy solution. I think people are afraid of it, because they don't know how to fix it. They don't want to be involved in things they don't know how to fix. That's my perception.

People need community. People need companionship. It takes an incredible amount of effort to seek relationship with people who may are different whether it be due to physical or mental illness, or whatever the case may be.

**Literature Review**

Several of the books reviewed in this project revealed stories of people who felt excluded from the life of the church while they or a loved one were in crisis with a mental illness. Due to some scientists negating the reality of the spiritual aspects of a person, distrust for faith in God has ensued, but as mentioned there are some scientists like, Dr. Matthew Stanford, who help start MHGA and thus, given Biblical and Theological considerations for people affected by mental health conditions.

In chapter two, reference was made to a curriculum, called HOPE, which was written specifically for people struggling with mental illness by Saddleback Church. In the introductory videos of HOPE, Kay and Rick Warren mention John Swinton's encouragement to consider the concept of radical friendship as the real need for people affected by mental health conditions. Swinton shared his observation:

> …daily I encountered people who were in desperate need of the type of inclusive community the church is called upon to be—people who, while often requiring

> professional help, needed much more than medicine and therapy; people with long-term mental health problems who were lonely, isolated and broken, and who were desperate to find a place of belonging where they could encounter relationships that would enable them to find value and hope in what was very often a profoundly hopeless and valueless existence; individuals who needed to learn what it means to love, to be loved, and to experience the love of God as it was expressed within his fellowship on earth, the church (Swinton 25-26).

Swinton proposes that "inclusion" is not enough. In a crowded room people can feel just as lonely as being the only person in the room if there is no connection, no reciprocity of a person, no honoring of the person. At the core of every person is a need for belonging. At the heart of this "form of ministry lies the struggle to create an atmosphere of acceptance, respect, and understanding within Christian communities" (Swinton 165).

Jean Vanier, founder of L'Arche, is a Frenchman who was humbled and inspired to create communities for people with intellectual disabilities (*The Heart of L'Arche* Vanier 9). There are now over one hundred communities in at least thirty countries and he has written extensively about what he has learned in the process of founding this organization and developing relationships with people of intellectual disabilities. In his book, *Becoming Human,* he talks about the importance of belonging: "It is in belonging that people discover what it means to be human. When we begin to believe that there is greater joy in working with and for others, rather than just for ourselves, then our society will truly become a place of celebration" (Vanier 66-67). In consideration of creating a faith community that has a positive, life giving, healing, and hope connection can be made to Vanier's statement about the purpose of the L'Arche communities, which is "to

help people move from their broken, negative self-image into a positive one. We try to help them move from a desire to die to a desire to live, from self-hatred to self-love" (138). Rather than condemning or criticizing someone for their condition, Vanier encourages people to seek oneness in the belonging of relationships as humans when they are vulnerable and real about their flaws and the need for each other.

In her writings, Amy Simpson expresses the feelings of exclusion families feel when they have loved ones that struggle with mental illness. Exclusion is not necessarily the lack of resources, but in the lack of acknowledgment. While growing up and as an adult, she continues to observe churches that struggle with how to respond to people with mental health conditions. There is a silence that pervades faith communities like a fog with stigma and it deepens the divide of marginalization. There is an over spiritualization of mental illness that calls forth a comparison of humans so that people are divided into categories of normal and abnormal. As mentioned in chapter two, Amy Simpson told her story of her struggle with the silence that she experienced at church when her mom went into a catatonic state while she growing up. In a phone conversation with Amy Simpson, the researcher asked her what she had learned since the writing of her book. She admitted a struggle to find organizations that gave a "Christian" perspective to answers people with mental illness might need to hear. Since the writing of her book, she learned about *Mental Health Grace Alliance* and *Fresh Hope.*

**Biblical/Theological Review**

There are three stories that are important to review for this first finding: first, the story of the paralytic in the Gospel of Mark, secondly, the story of the Lazarus being resurrected from the dead in the Gospel of John, and thirdly, the parable of the lost sheep

in the Gospel of Luke. Each story highlights the radical friendship of Jesus. God sent Jesus into the world, not just to create a way to include humanity into his family but also to create a deeper relationship with people by his Spirit. A person can be in a room full of people, but still feel very lonely. Until a person's spirit touches another when they are accepted and embraced with more than just a physical touch, there is no connection that creates a sense of belonging.

In the second chapter of Mark, a picture is painted of people who have heard of Jesus' authority over demons and illness, so they crowd around his Capernaum home. Maybe some of them needed healing or maybe some of them just wanted to see for themselves if Jesus really performed miracles. The story claims that there were so many people in the house that a paralyzed man was unable to get through a door or window to ask Jesus for healing. In what appears to be desperation, four of the paralyzed man's friends created a hole in the roof of the house so they could lower their friend down in front of Jesus. This story is among several that reveal Jesus' authority in these first chapters of Mark. This story unfolds because of the depth of belonging, or radical friendship, that was displayed to show love to the paralyzed man. What if the church went out of their way to show radical love to people who are affected by mental health conditions? The church is more likely to accept people with physical ailments than to include people with mental health conditions so I ask the Church should consider responding as these friends did with radical friendship.

Lazarus was a friend of Jesus who died, was placed in a tomb, and then was brought back to life four days after his death. The story was recorded in the eleventh chapter of John. The story foreshadows the death and resurrection of Jesus and also the

resurrecting power that is available in our lives as well. In John Swinton's book, *Resurrecting the Person*, he states:

> The model of friendship presented in the life and work of Christ offers real possibilities for therapeutic change. Committed friendship that reaches beyond culturally constructed barriers and false understanding and seek to "resurrect the person"—who has become engulfed by their mental problems – is a powerful form of relationship (Swinton 139).

An important piece to this story is the command of Jesus for the people to act. First, he commanded the people to remove the stone of the tomb where the dead Lazarus laid, and second, he commanded the people to remove the cloths that bound Lazarus. So here again is a story of how radical friendship is important to help someone with companionship in life. How might the Church help people with mental health conditions to be released from the shame, fear, or rejection that could be considered analogous to the strips of cloth that bound Lazarus? Jean Vanier also spoke about belonging and acceptance as it is lived out in the communities of L'Arche, "[we] help people move from their broken, negative self-image into a positive one. We try to help them move from a desire to die to a desire to life, from self-hatred to self-love" (*Becoming Human* Vanier 138).

The third story is a parable that mirrors the reception of God when one of his children has been lost and then found. The story about a shepherd going after a lost lamb is told to a group of Pharisees who think they are righteous and good. They questioned every move that Jesus made. This story was to challenge the Pharisees' understanding about who is lost and in need of care. They certainly did not believe that they were lost.

The story offers hope to look to Jesus as the rescuer and healer just as a lamb would look to the shepherd as healer and caretaker.

God is constantly in communion as Father, Son and Holy Spirit. The Triune God offers the greatest example of what it means to create belonging. In the beginning God created all that is seen and unseen and then sought to connect with his created. The scriptures even give insight into the conversation. God did not put the world in motion as a way to include creation in his resume. Humanity was created to have a need to belong to him and one another in companionship. Humans are innately given a need to recognize that they belong to God and to have connection with each other as his people.

### Second Finding: The Church's Responsibility for Social Justice

Because the scriptures tell the Church to be a voice for the voiceless, Christians have a responsibility to advocate for people affected by mental health conditions through education and being educated so the church can effectively serve people in our communities.

## Personal Observation

Prior to this research project, I was aware that various hospitals had been established and developed through the efforts of various Christian faiths like the Methodist Hospital and Saint Luke's Episcopal Hospital in Houston, Texas. In Orlando, another example of the Church administering to the physical needs of humanity is the Seventh Day Adventist Church with a network of eight hospitals throughout the city. As a Pastor serving in Texas for ten years, I knew of various Christian counseling centers like The Krist Samaritan Counseling Center and The Healing Center in Houston. Both of these started by Protestant denominations. As a student at Asbury Theological Seminary,

I have learned about the Mental Health Counseling Degree program at their Orlando campus, and one similarly offered through the Reformed Theological Seminary. God has blessed many Christians with gifts and vision to address the needs for the physical and psychological aspects of people. However, there are still so many that lack understanding of mental illness and they even have fear of discussing it.

When people are struggling to make sense of their pain often they turn to the church for answers. As an example, I remember that after 911, the day four planes went down in a terrorist attack that killed thousands of people on American soil, people flocked to churches for answers has to why or how this could happen. Prior to this project, I believed that it was the church's responsibility to educate people about various issues in society like how to respond to a terrorist attack or how to respond when a person has cancer or is a victim of sexual abuse. Throughout American history, churches have gathered in solidarity against injustice and offered a voice for the voiceless in situations like slavery, civil rights and poverty. The Church has provided for specific needs in their communities by building hospitals, food pantries, employment training centers, schools, and in some cases, counseling centers. Since working on this project, I have learned that people look to whoever is willing to lead to a solution; sometimes people look to the government, sometimes to a community organization, and sometimes people look to a religious entity. A person may not be able to learn everything about cancer or diabetes, slavery or civil rights, literacy to learning disabilities, mental illness or mental health conditions. However, the Church has a responsibility to know enough to represent Jesus in the midst of these elements in life or people will look elsewhere or maybe even ignore that which they do not understand.

People need holistic care; to offer holistic care is to recognize that we as humans are spiritual, emotional, physical, mental, and relational beings. Humans have a mind to reason and solve problems with, emotions to stir us to respond, bodies to enable action, relationships to create companionship and a spirit to empower and connect us with the divine for strength to do that which we cannot do on our own. The Church is the representation of Christ to bring peace and love to all people.

I discovered in this project that all of the research participants felt the church should educate people about mental illness. This doesn't mean they take the role of the scientists, therapists or psychiatrists. The church should partner with professionals who have studied a great deal in this arena and then present the information in various ways like my previous church did with a one-day seminar, through sermons, prayers or testimonies. A twist in this understanding about education came in my conversation with the author, Amy Simpson, when we talked about the responsibility of the church. She suggested that, "the church has a responsibility TO BE educated." The Church is not expected to be the expert, but to be educated enough to respond to people with or affected by mental health disorders.

In conversations before and during this research project, I found myself struggling to find the right terminology for discussing mental illness or mental health. The year before starting this project, the church where I was serving held a conference focused on educating people about mental illnesses like depression, bipolar, anxiety, schizophrenia. During the year prior to the conference, several people had shared that they or these types of illnesses affected a loved one and they wanted more information about mental health and how to respond to loved ones who struggled. We decided to title the conference as

*Rethink: Mental Health,* which included the founders from the organization, *Mental Health Grace Alliance*, in leading our agenda. I knew prior to this project that there are people in and out of our churches asking questions about mental illness, how to live with people who have mental illness and how to know who to go to for help and how should I talk about it respectfully?

As I started this research project, I was drawn to the term "mental illness" because my hope was geared toward creating a church model for people affected by mental illness instead of the "mentally healthy," after all, Jesus came for the sick, not the well (Matt. 9:12). Along the way, I discovered NAMI, the *National Association of Mental Illness*, the *National Institute for Mental Health and MentalHealth.gov*. Obviously, each of these organizations use different terminology related to the same topic. In the surveys, questionnaires and interviews there was a lot of discussion regarding what terminology should and should not be used in their churches and community organizations.

In one of the interviews with a church pastor, he told me that he struggled with filling out the survey/questionnaire that I designed because he did not know what I meant by "mental illness." He acknowledged the broadness of what that term could or could not encompass so he was hesitant to give answers. During this research project, I found that defining mental illness or mental health was difficult but helpful and actually vital to the understandings or misunderstandings related to the subject matter of this project. All three of the counselors that I interviewed said they did not like the term, "mental illness," because they felt it had a negative connotation. The Director of NAMI acknowledged that the term, mental illness, was a part of their organization's identity. However, sometimes it is helpful to use terms like mental health disorders like the DSM5 (Diagnostic and

Statistical Manual or Mental Health Disorders: 5th Edition), which lists over two hundred mental health conditions.

All four of community organization leader participants were concerned about labeling or identifying a diagnosis as a mental illness, because they believed this would give a greater propensity to the illness, versus their identity as a person. Each of the pastors or church leaders interviewed said they do not use the term, “mental illness,” because of the weight it carries or the assumptions that are made from it due to the stigma associated with any conversation around it. Two of the four church leaders that gave an interview said they were open with their mental conditions and as a result, people would come to them and share their struggles. All of the church leaders also acknowledged that sometimes mental illness is due to an emotional wound so sometimes they use that term, or they use words like mental issues or struggles. There were two leaders that gave definitions that I considered insightful to share in this paper. In my interview with Ch8 they stated:

> My definition is “a person who is outside of the norm, the kind of established norm in terms of how behavior is supposed to occur.” That is the most broad definition I would have. I mean I would include: “the ability to cope, the ability to fit within societal groups, as well as taking care of themselves and taking care of others,” that sort of thing. Basically, “a person who is not in their behavior matching established norms.

Then in an interview with Ch1 they stated:

> I think I would probably use that term (mental illness) to categorize a very broad spectrum to talk about mental and mood disorders; certainly anxiety and

> depression would come under there, OCD would come under there, addiction would come under there. Partially because I think I have met so many people in my time in our ministry who have addiction and use something to help with their mental health issue. It seems to be a medication they can tolerate to cover up mental illness; anything where our brain is sabotaging our bodies and our relationships.

As a result of research, I have decided that I want to use the term, "mental health conditions," when referring to something related to mental health issues, disorders, disabilities, problems or illnesses. A mental health condition is a feeling, or way of thinking or mood that diminishes a person's life in such a way that they are unable to cope with day-to-day living; some conditions are severe or chronic while others can be managed through therapy, practices or medication. I believe it is also important to say that a person with a mental health condition can lead a meaningful, even productive life.

As stated earlier in this paper, one of the reasons for this project was to raise awareness and courage within the Church so that advocacy and acceptance would rise for those with mental illness. Many people hide their struggles for fear of rejection or shame. While on a forty day fast in 2014, the author of this paper saw a play in which a woman used the term "*invisible"* to describe how she felt when she attended church. The play, *Women in the Pit*, was written by Joyce Sylvester, and tells the story a woman pastor's struggle with finding her place in life let alone which pulpit she should preach within As the play proceeded, it was made known that the woman preacher was not being authentic with her past nor supportive to a daughter who felt like a victim of sexual abuse, alcoholism and insignificance. The daughter said she felt "*invisible"* when she was in

church, but she felt alive when she was among the homeless in the park. Seeking those who feel invisible in the church has lead the author of this paper to ask the question, “Could it be that people do not enter the Church or attend a church, because they feel they have to wear a mask to be seen?” Eliminating stigma happens when people talk openly about mental illness or mental health while pursuing life with a person who has a mental health condition rather than shunning them.

As mental illness was discussed in the survey/questionnaires and interviews the reality of the shame associated with mental illness was evident. In an interview with pastor Ch1, it was said:

> With mental illness people think things like “Oh, they are crazy,” or “Oh, they are schizophrenic, or they have OCD” or something like that. I don’t think that is what the term is intended to convey, but often it does. So that’s the term. The stigma associated with mental illness is its’ own category, because they are so poorly understood depending on the context.

In an interview with one of the community leaders CO2 gave a prominent pastor’s story as an example of how people respond towards people who have mental illness:

> When we talk about illness like suicide, there is this way of thinking that “oh, my you can’t have someone with those thoughts working with us,” however, it’s just an illness that needs to be treated. Again I mention Bill Barnes who talked about his mental illness. It was a big deal that he spoke openly, because people saw him do all these great things and yet he came around and shared that he was the same guy that everyone it knew even though he had depression. He had depression for 20 years. For him it was such a history. He figured out that there was no logical

> reason for him to feel the way he did and yet he showed he could live life and do all these amazing things with depression. When we say "illness" we may think of it as when someone as diabetes, cancer, asthma or some chronic condition. If you think of it as like when someone as asthma you don't think twice about it, but when someone comes to church and says, "oh my daughter, has whatever and needs some extra time to walk out of the church," then people's heads turn and you see this change in people's receptivity of a person, because of the stigma of mental illness.

Sometimes the word, "stigma" is used, but across the board in the completed survey/questionnaires that I designed, church leadership used the words associated with "socialization" of people with mental illness as a dimension that has to be handled differently than with the "normal" people if you will. Because leaders are saying there needs to be "normalization" for people affected by mental illness, then there must be a differentiation which causes me to wonder if this is their way of saying there is stigma with mental illness just as there was with leprosy in previous centuries.

**Literature Review**

The literature that I reviewed for this project verified the belief that people, like myself have been afraid to share their own stories of struggle with eating disorders, or depression, or being bipolar or having a mom who goes in and out of a catatonic state due to schizophrenia. In Amy Simpson's book she shared the perspective of a friend about stigma:

> The confusion of the culture is mirrored by the confusion of the church, which is mirrored by the confusion of Christian families. Christian families are wondering,

> "Who can I go to: who will listen to me? And ideally, who will listen to me with my perspective on life? My perspective that tells me there is a God who loves me, who sent his Son to die for me." Well, that's the church. There are deeper theological issues and doubts that the church needs to obviously step into. But again, there're as confused as those families.

Stigma exists for people in our communities and in our churches. If the Church is to represent Jesus Christ in the world, we need to offer hope by providing a safe space for people to come with vulnerability and transparency. In John Swinton's work, he has suggested that there is really no one that is the same, in essence, all humans have differences so the quest to be with people that are same is somewhat futile. He says:

> We might, for a variety of reasons, agree to choose to mark out some people as normal and others as abnormal. However, the truth is that the only real norm for human beings, even at a genetic level, is difference. When Paul (Gal 3:28) tells us that there are Jews, Greeks, barbarians, males, females, he is indicating a fundamental fact about the way the world is: We are inherently different. The only question is why we choose to treat some forms of difference differently (Swinton 179).

Humans tend to seek out people that are like themselves as Swinton points out. It could be concluded that this is why so many churches have congregations that "look" the same. In general, humanity struggles with pride and the desire to be the considered the best, so it is conceivable that churches could struggle with accepting people with disabilities or dysfunction. There are some churches doing a great job of offering resources for people with disabilities, but there are some that are not.

People living with a mental illness are not the only ones impacted. In *Sons of Madness: Growing Up and Older with a Mentally Ill Parent,* author, Susan Nathiel, shared twelve stories of men who reflected upon their experiences of growing us as sons of mentally ill parents (Nathiel 172) :

> The stigma around mental illness affects not just the person diagnosed but everyone connected to him or her family ties. I call it "shame by association" because many people react as though it's a contagious disease. They not only avoid the stigmatized person, but also avoid anyone connected to that person, as if irrationally afraid of some kind of psychic contamination.

Silence is just as difficult for a person to deal with as bullying someone with yelling. Over and over in the books reviewed for this project people talked about the silence and isolation associated with living with a mental illness or having a loved one with a mental illness.

## Biblical/Theological Overview

The Bible may not suggest that a person be "educated about mental illness," however, it does give stories of how Jesus responded to people living in shame and he modeled for us how to deal with issues that people in the culture want to use to offer condemnation. For example, in John 8:1-11, Jesus was at the Temple when a group of scribes and Pharisees brought a woman who had committed adultery before him as if to insinuate that she should be punished. The Temple leaders of this story knew that women who were caught in such a comprising position were to be stoned according to Jewish law, but Jesus didn't pick up a stone to put her to death or tell anyone else to do that either. Instead, Jesus commented on the stature of everyone by saying, "Let anyone

among you who is without sin be the first to throw a stone at her" (John 8:8). Not one person threw a stone; they all turned away. The woman was shamed in public, but Jesus chose to be a voice for her when she was in need of help. Shouldn't the church be a voice to defend the people living with mental health conditions just as Jesus was a voice for this woman? We all have sin, we all need grace and we all need the Church to be like Jesus standing in the gap for us.

Another biblical example of being an advocate for people in need can be found in the story of the Good Samaritan from Luke 10:25-37. It was a lawyer who asked Jesus how to have eternal life. Jesus responded by saying he should "love the Lord your God will all your hear, with all your soul, and with all your strength, and with all your mind, and your neighbor as yourself" (Luke 10:27). The lawyer acts as if he doesn't understand what Jesus means by neighbor. Jesus uses a story to reveal that the people we are supposed to care for are the least likely; we are to offer whatever gifts we have whether it is financial, physical, relational, intellectual or spiritual resources.

There are many other scriptures that implore action when there is social injustice and a need for advocacy. Proverbs 31:8-9 says: "Speak out for those who cannot speak, for the rights of all the destitute. Speak out, judge righteously, defend the rights of the poor and needy."

**Third Finding- Discipleship and Leadership in the Midst of Brokenness**

Involvement in the life of a church should include discipleship and leadership even in the midst of brokenness and pain of physical, mental or emotional illness. Dimensions of ministry vary from person to person with or affected by mental health

conditions, and therefore, a persons' ability to be involved in the life of some church models, including discipleship, may be questioned.

**Personal Observations**

As stated earlier in this project, I have heard a variety of negative references to people with mental illness; the shame associated kept me from sharing my own struggle with depression and anxiety. In addition to the struggles I dealt with personally, I developed relationships with several people who struggled with depression to the extent that they had to take medication daily to deal with day to day living. I also learned about a friend's daughter going through diagnostic testing to find out that she was diagnosed with bipolar. All of the people I mentioned were involved in the life of a church in some way, but they kept their struggles private. Each one was involved in a Bible study or small group and attended church regularly. Over the course of this project, it has seemed that more and more people have broken their silence in order to share their struggles with mental health conditions. Some people I know shared within their involvement with a church and some were not.

During this project, it was discovered that all except one of the participants believe that there are different dimensions needed in this type of ministry. These dimensions were described in ways such as: sensitivity, listening, flexibility, socialization, normalization and patience. There were a few comments made about expectations being different depending on how debilitating someone's condition is for coping with life. Three of the participants noted that expectations for what a person "could or could not do" were of consideration when thinking about the dimensions of this ministry. In one of the interviews with a pastor, it was said,

> In my opinion, very little (is different in ministry to people affected by mental illness). Acknowledgment of the illness and its impact should not be overlooked, but as a minister my goal is to point people to forward movement in relation to Christ. The toolbox for aiding that person may be slightly different, but the goals should be the same.

It could be said that this pastor is the only one who considers discipleship as part of the dimensions of this ministry. Through the evaluation the other answers received, it could be said that there is not a cookie cutter way to be in ministry with people affected by mental illness, because each person is unique with uniqueness to their condition. In the results of the completed tools, when mental illness was mentioned it seems their responses associated the ministry with the acute, more severe cases as unique and in need of personalized treatment rather the multiple other less visible conditions.

In a phone conversation with Amy Simpson, it was mentioned that a person with mental illness should and could be considered for leadership within a church. She noted this is one of the ways to eliminate stigma. When we include all people in leadership, it opens up our perspectives and brings in new voices that may have blessings that could be missed. Simpson did acknowledge that it would be difficult for her mother to be in leadership at a church, because of the severity of her illness at times placing her in and out of deep catatonic consciousness at times. Simpson mom may not have been a leader at the church, but her leadership did lead Simpson to know that her mother loved Jesus and cared for each of them even in the midst of her illness.

As we discuss the importance of discipleship and leadership, I want to mention David Mandeni who is a Christian and overseer of the mental health ministry HOPE, at

Saddleback. Mandeni shared his testimony of God's power in his life helping him with his diagnosis of schizophrenia twenty years ago. Through treatment and support of family and friends, including medication, he worked in behavioral health for twenty years and most recently has been developing the mental health ministry. The illness, schizophrenia, is not the differentiating factor for ministry, the person's identity and needs must be accessed even more than a list of symptoms applied. Both of the people just mentioned know Jesus, but each have a different journey with mental illness and each are a beloved child of God.

## Literature Review

In an article recently a woman of prominence in the Christian culture of America, Rebekah Lyons, was documented as saying mental illness was something that could be prayed away. Lyons had an experience in which her daughter had an anxiety attack so they prayed and it went away. Later in a talk she was giving at the "IF" conference she was talking about the power of prayer, but she didn't have awareness of how people with mental illnesses that have not gone away would receive her comments ("What Made Mental Illness A 'Sin'?" Lee). Sometimes it is assumed that a person has to be healed from a mental health condition, before they are "set right" before God and useful for his kingdom. In reality, God uses people's brokenness, and he wants even people affected by mental health conditions to be disciples.

Michael Frost is a prominent pastor and church planter from Australia who wrote about discipleship in his book, *Surprise the World: The Five Habits of Highly Missional People*. He suggests that habits help a person develop their relationship with God and others so that they become a part of who one is. He acknowledged there are very simple

practices that can be done to show who or what a person's life is really about. The habits may be different for different people, but he suggests these: blessing (offering a blessing), eating (sharing a meal), listening (being in silence), learning (spending some time in scripture), and sent (being connected in the community outside of the church) (Frost 22). Each one of these practices reveal dimensions that are helpful in discipleship. To be a disciple is not about knowing everything there is to know about Jesus; it is about who a person becomes while knowing him. So, a person with a mental health condition does not have to be filled with knowledge but can be in pursuit of Jesus with his love and grace.

**Biblical/Theological Review**

After supper on the night that Jesus shared his last meal with his disciples, he wrapped a towel around his waist, poured water into a basin, and washed the feet of each disciple. This action of Jesus as recorded in the thirteenth chapter of John shows how Jesus adapted in such a way that showed his disciples how much he wanted to serve them. This action set the example for Christians to follow in serving each other. Jesus showed his willingness to alter dimensions of ministry as needed to show his love, mercy and grace. Ministry should always point to who Jesus is and should allow for change as needed.

There are many scriptures that suggest discipleship; to be a disciple is to learn, but even more than that it is to follow and abide in Jesus. In the fifteenth chapter of John, Jesus is teaching the disciples what it means to follow him and what it means to know Jesus. Disciples must abide in Jesus just as a branch is connected to its trunk and its roots. The branch bears fruit, because it is connected to its base, the vine, and so it is with a disciple. Disciples grow and bear fruit when connected to giver of life, Jesus.

**Fourth Finding- Blending Church Models**

There should be a blending of church models in developing a church or ministry for people living with or affected by mental health conditions.

**Personal Observations**

When I started this project three years, I was in the process of implementing a vision the Lord have given me for a new church called The Distribution Center. This faith community seeks to reach people with or affected by mental health conditions. A board of five people was created. We registered with the state and federal governments, and over time twelve to fifteen people started gathering at our house for dinner, discussing scripture, sharing prayer, testimonies and communion. Over the past year we have participated in various community events, and we have been advocating for mental health. We have discussed opening a coffee house that includes a resource center with space for creative arts and support groups for people affected by mental health issues sometime in the near future. For now, our gatherings reflect that of a house church with table fellowship. We have incorporated some of the findings included in this project from the recovery minded model or fresh expression models as well.

Upon attending the New Room Conference in September of 2017, I heard a pastor talk the about this Dinner Church he started in Seattle Washington. My husband turned to me and said, “Wow, that is what we are doing with our new church.” Some of the recovery ministries that I have visited included sitting down and having a meal prior to a worship setting so table fellowship is obviously important. Gathering at the table creates space for conversation that may leads to confession when people are struggling or

wounded and allows for more opportunity to speak truth and offer encouragement to one another.

In the closing year of this Doctor of Ministry program, I was sent to Thailand to learn about church planting in a country where Christians were a minority. I had heard and read about house church but had never experienced being involved with one. I had grown up in traditional, institutional churches. In one of the house churches we visited in Thailand, we spent two hours sitting on the floor in a service of worship. We prayed together, shared testimonies of faith, shared communion (with sticky rice and hibiscus tea), offered our tithes, read scripture, and sang songs. At the end of our time in service, a woman asked that we pray for a woman who was feeling depressed, because her husband struggles with alcoholism. It was amazing to hear them ask for prayers with this type of understanding for mental illness with no one shaming anyone. It was also amazing to see the love and support around this woman. There was something so sweet about our conversation of our faith, sharing communion and praying for one another.

In a conversation with my daughter after my Doctor of Ministry immersion trip to Thailand, I told her that I was really moved by the community experience with the house church in the north eastern part of the country that I just described. She acknowledged that this community experience is what she thinks is missing in larger church settings. Although I had not been involved in a "house church," she suggested that we, our family, had been involved in a "house church" when we shared dinner, fellowship, accountability and our faith with our friends, the Donaldsons and the Kennedys over the years. We may not have called it house church, but it resembled what we read about in the scriptures.

In conclusion, there are cowboy churches and traditional churches. There are churches with specific ethnicities or languages recognized. There are various denominational churches and non-denominational churches. In the past thirty years, there have been various recovery minded church, and now I would like to suggest the distributing church where healing and hope are distributed to all people as we even embrace people with or affected by mental health conditions.

**Literature Review**

In an article by a Pastor Reggie Abraham, he revealed how he as a pastor learned things from someone who struggled with schizophrenia that he never would have learned were it not for his friendship with a woman named Tammy. He learned that his image of God was too small, his concept of ministry kept him seeking order. However, God was sometimes unclean and disorderly. He also learned he thought he had courage, but he realized it takes a great deal more courage for someone with mental illness to sit in the pews of a church building among people who stereotype and lack understanding of mental illness. He also learned that friendship is so important for people with mental illness, because it shows a person that they are valued beyond their mental illness. This is why it is important to have a faith community focused on reaching people with or affected by mental illness or mental health conditions. It has to be a part of the DNA of the church planted. This does not mean that this new church model should be a recovery model either, because mental health conditions bring a different set of issues to a person. It is not their identity, but it is a part of their story.

The aspect of recovery minded churches that is vital to a distributing table fellowship model is the need to see authenticity and truth and to share these values with

one another. Brene' Brown defined love and belonging in her book, *The Gift of Imperfections*:

> We cultivate love when we allow our most vulnerable and powerful selves to be deeply seen and known, and when we honor the spiritual connection that grows from the offering with trust, respect, kindness, and affection. Love is not something we give or get; it is something that we nurture and grow, a connection that can only be cultivated between two people when it exists within each of them. belonging is the innate human desire to be part of something larger than us. only happens when we present our authentic, imperfect selves to the world, our sense of belonging can never be greater than our level of self-acceptance (Brown 26).

In many institutional churches or large gatherings, there is a trend to have the room dark and to give space for people to have privacy and silence rather than exposure and openness. In a house church or table fellowship model, it is more difficult to wear a mask. There is an opportunity for bringing forth your imperfection and brokenness and an invitation to be cross any barriers to be a part of something bigger than yourself. There is an opportunity to claim your place of belonging, your place of connection even with mental health conditions. Abraham referred to John Swinton's book, *Resurrecting the Person*, as a resource for understanding how to care for people who have mental illness or disorders and how to build friendships as well:

> The model of friendship presented in the life and work of Christ offers real possibilities for therapeutic change. Committed friendship that reaches beyond culturally constructed barriers and false understandings and seeks to 'resurrect the

> person'—who has become engulfed by their mental health problems—is a powerful form of relationship. It offers hope and new possibilities to people with the types of mental health problems that are the focus of this book (Swinton 138-139).

To encourage friendship seems like something the church should already be doing, but relationships are hard and yet so critical.

Table fellowship is common to all people; it can break down barriers and create opportunities to share. It is an opportunity for a fresh expression or "a demonstration of the in breaking of the kingdom of God" (Jones, *DTS Magazine*) "We need to recover table fellowship as a spiritual discipline in order to strengthen the bonds of spiritual friendship among believers who are walking together on the road of discipleship" (Jones) In Vernon Fosner's book on Dinner Church, he quotes theologian John Crossnan, "if we were to watch Jesus when he walked the earth, we'd mostly see him healing and eating. What an interesting two-point mission statement for a church: healing the broken and eating with the sinner" (Fosner 29).

**Biblical/Theological Review**

House churches were mentioned several times in the New Testament: Archippus's house in Philemon 1:2, Prisca and Aquila's house gathered in 1 Corinthians 16:19, Nympha's house is mentioned in Colossians 4:15, Epanetus's house in Romans 16:5, Lydia in Acts 16:40 and John's house in Acts 12:12, and Gauis' house in Romans 16:3. All of these house churches would probably have participated in the remembrance of the Last Supper which would have been observed as that which is described in 1 Corinthians 11:23-26, Luke 22:14-3, Mark 14:22-25, or Matthew 26:26-29 or even in the Walk to

Emmaus story of Luke 24:12-49. Each of the stories in which the bread was broken, indicates the hearts were warmed and eyes could see the incarnation of Jesus (Luke 24). There is something unique and special about sharing in a meal around a table and in being a community.

Additionally, there were several occasions in which Jesus shared a meal with people who would have seemed to be in the margins of society and some that were wealthy. Jesus showed that it is good to cross all lines that have been drawn to divide people by sharing at a table. One of the most spoken about encounters at the table is the woman with the alabaster jar story in Luke 7:36-50 or Matthew 26:6-13. The people around a table would not have spoken of the servants around the room let alone speak directly to them. Jesus shows the women that she is valued, and all people are shown a way of connection and belonging that was unusual for their day and age. And then there were stories like in Matthew 9:10-11 or Mark 2:15-17, when Jesus reclined at the table with tax collectors. These stories also show how Jesus wanted bring people on the margins of society into fellowship. All people matter and find equity sitting around the same table sharing openly what is going on in one’s life.

As indicated in review of the materials and research, it is recommended that people with mental illness or people affected by mental health conditions get opportunities to share their stories and use their conditions to bring hope and encouragement to others. It is also recommended through this finding that faith communities seeking to reach this demographic of people could be developed through a table fellowship model. Sometimes having smaller groups in a more relaxed setting can create less anxiety and greater potential for friendship to develop. And the third

recommendation that comes with this finding is the need to develop a discipleship dimension for people affected by mental health conditions rather than just a resource list for practical life necessities. The discipleship guideline developed from the second chapter of Acts would be a good foundation along with the consistent gathering of table fellowship church model.

**Fifth Finding- The Practice of Healing**

The practice of healing would be useful for churches who are developing ministry with and for those affected by mental health conditions. Although participants did not talk about healing in the interviews, surveys or questionnaires, there was important information about the practice of healing in the literature review.

## Personal Observations

In 1998, I recognized a need for inner healing. I was not hemorrhaging physically but lived in the poverty of spirit with emotional wounds. With the help of a counselor, I was able to work through why I was struggling with an eating disorder. In the fall of 1998, I was invited to participate in a three-day retreat called the “Walk to Emmaus.” During prayer on this retreat, I told God that I felt unworthy to be like the dogs who seek crumbs under the table (Matt. 15:21-28), but I needed healing just like the woman hemorrhaging who grabbed the fringe of Jesus’ garments as described in scripture (Luke 8:40-44) After attending the weekend retreat, there was an opportunity for weekly accountability, prayer in small groups, quarterly table fellowship and worshipful gatherings in larger groups. These experiences gave me personal insight that therapy along with a faith community could help me with the process of healing.

Prior to this project, I had participated in healing ministries by observation, praying with or for someone or by leading a healing service. There were times that I observed what could be considered a miraculous healing after someone was prayed for, and there were times I observed no change in a person's situation. I have been a part of a faith community that offered prayers for a person in which they were not healed, but the bonding of turning to God together changed the community. I have participated in healing services, attended and participated in prayer vigils focused on healing, visited people in hospitals and homes when they wanted prayers for healing. I have read books on healing, and I have attended retreats focused on healing. I have learned that healing can take place in many ways and means more than bringing forth a miraculous cure. Ultimately healing comes through the reconciliation and renewal brought forth in a relationship with Jesus Christ by the power of the Holy Spirit.

I have observed my daughters having both positive and negative experiences with healing prayer. When my daughter, Casey was five, our pastor called for people to come forward to ask for healing during a worship service. Casey asked her dad to take her to altar for prayer and anointing of oil. She had been suffering from severe eczema due to allergic reactions to corn. Casey was healed; she was cured to the point that she was able to eat corn without infectious outbreaks from then on. At the age of nineteen, while in college, my oldest daughter, Kelsey, developed symptoms that mirrored rheumatoid arthritis. My family and many others prayed for Kelsey from a distance, and on her own. Kelsey begged God to heal her. Her healing came in a different way than expected; she became pregnant and her symptoms subsided. She considers her child her miracle, but questions why God did not completely take her symptoms away like her sister.

When I became a pastor, the Senior Pastor of the church where I was serving at the time asked me if I would pray for people who needed healing at the end of each Sunday's worship service. One week the Pastor's sister came in and asked for prayers of healing on a blocked artery. Her doctor suggested that she might need a procedure to correct it. The following week, the sister told me the doctor told her that she had nothing wrong with her artery. She was healed so she would no longer need medical attention for the issue at hand. While serving at that same church, I was asked to lead a healing service for an eight-year-old girl who had a rare disease that required brain surgery. After we, her school and her family, prayed for her she still required the surgery and the process of treatment and care. Her illness was not eliminated, but she did receive the healing miracle of modern medicine. These are just two of the many situations in which I was involved in a request for God to heal while serving in ministry.

Upon review of the surveys, questionnaires and interviews, I noted that no one really talked about the practice of healing. If you look at the tables in chapter four you will not see "practice of healing" listed as an important practice of the church. It occurs to me that the leaders interviewed talked about their ability to provide counseling services or suggestions on where to go for support groups, but there was no mention of the practice of healing. One of the church pastors did mention that a faith community should not focus on mental illness, because the focus should be on the Gospel of Jesus Christ: "We are the church commissioned to be the salt and light. We should not be focused on the illnesses; (we should) be seeking hope and healing. Christ is where this is ultimately found." I would not argue that this should be the focus. However, faith communities are called to meet people where they are and in whatever need they have. Jesus would ask

people what they want before he would heal them. There is something to be said for acknowledging that illness or pain exists as a person turns to the healer. The call to heal is not necessarily the call to cure: it can be a call to healing in modern technology or a call to walk alongside someone to help them see the miraculous that comes in day to day living.

In January, I audited a class on healing taught by Dr. Steve Seamands at Asbury Theological Seminary.  We talked in class about the fact that our churches are quite good at following Jesus' example to preach and teach, but we have not embraced the call to heal. People need healing of different aspects in their lives; sometimes physical, sometimes emotional, or relational, mental or spiritual. Sometimes Jesus spoke to a person's need for inner healing by offering forgiveness of sin, sometimes healing was related to something physical, and sometimes healing came in the form of casting a demon to give a person mental stability.

**Literature Review**

Healing does not occur in the same way for each person. Healing can be instantaneous and it can be a long process. If the church is not receptive to conversation about what is painful in their lives like struggling with depression or having eating disorders, then how can there be healing? The expectations of the Church to be a certain kind of "healed" community puts people at distance from being their true selves and being real with others. This has brought to the forefront the understanding that a church ought to promote being community that practices healing. Swanson described it this way: "Churches can be places of the healed, the healing and the healers" (Swanson 148).

Additionally, healing is pointing to the healer. When a Christian is praying, there is more in the prayer than a request for God to change a situation in a particular way. It is an opportunity for a person or persons to change their perspective. Pastor Fosner says it this way,

> The prayer of healing is what releases the Healer to start walking with and intervening in a person's brokenness. We are doing Jesus and the person we are praying for a disservice if we only acknowledge the instantaneous healing event. Since the Healer most often works in daily progressive ways (Fosner 64).

In Doug Murren's book, *Churches That Heal: Becoming a Church that Mends Broken Hearts and Restores Shattered Lives*, he gives helpful guidance for creating a holistic, healing ministry. There is rich information about some of the obstacles to creating an environment for healing and there are helpful suggestions on what is needed. He says,

> Being healed and being made whole are necessarily the same thing. Healing can fix what's broken in our bodies or our minds. But God wants more for us. "Wholeness describes a state in which everything about is in right working order: our emotions, our self-esteem, our sense of morality, out thought patterns, our physical body, our spiritual faculties (Murren 89).

There is an acceptance of the idea that people are not going to arrive at perfection. People are in the process of "becoming" (98). Jesus is perfect and humanity looses "our ability to heal, the moment we fail to see ourselves as journeyers" (135).

There are some times that God does not heal a person when prayers have been offered up. This can bring confusion and even frustration. This is a reminder that there is

brokenness and death in this world. Christians live in a time when they can claim God's power for present and in hope for eternity. Thus, Christians claim God's power to see them through until they join him. In the meantime the church is to go into the world as Jesus commanded to teach and baptize and make disciples who make disciples to the ends of the earth (Matt. 28:20: Acts 1:8).

In the book, *Fountain House*, there is a fundamental premise that all people "need to be needed" (Doyle Loc 52). While working in a mental health facility John Beard saw the need to stress the importance of sociology in humanity (Loc 255). Humans have a greater propensity to heal when they have a social network. Healing comes through relationship with each other and within in reconciliation with Christ. Jesus came for the least, the last, the lost.

**Biblical/Theological Review**

The Bible is full of stories in which Jesus heals someone; each incident was unique. Sometimes Jesus would say to a person, "you are forgiven," instead of, "you are healed." Sometimes Jesus would touch the person or use an element like dirt to spread on someone's eyes to heal them from blindness (John 9:1-9). Sometimes, Jesus would heal people of not just their physical infirmities, but their emotional (John 21:15-19) and relational (Mark 2:13-17) ones as well. If people are going to be drawn to the healing power of Jesus Christ, the Church must be able exhibit what that looks like by speaking about the healing power in their own lives.

In the Gospel of Luke, a story of Jesus walking amongst a crowd when a synagogue leader named Jairus approached Jesus to ask for healing of his dying twelve-year old daughter (Luke 8:40-56). While on the way, a woman with a twelve-year

condition of internal hemorrhaging reached out to touch the hem of Jesus' cloak. Jesus felt the tug of the woman's faith, so he turned to find who had touched him. Jairus confronted Jesus without shame or fear, but the woman concealed her approach to Jesus. Maybe she was embarrassed or maybe afraid of his rejection. Men could approach men in public, but according to Jewish tradition a mean could not address a woman in public let alone a woman who was bleeding ("Luke" Wright 104). She would have been considered unclean or untouchable which meant she was to be kept at a distance while in her unclean state. It may be assumed, but it is a reasonable summation that the woman must have felt shame, desperation and powerlessness. There were a lot of rules for how to live with physical illnesses or irrational behaviors in the first century ("Disease" Sakenfeld 138). The woman stepped out in faith regardless of the rules in order to touch the one whom she thought might have greater power than any of the physicians who had treated her. Sometimes healing comes when two people pray and sometimes it takes a community to walk along side someone as they struggle with an illness or a chronic condition. Healing can be a journey that claims the power of Jesus and is exemplified in community that claims Jesus as the Great Physician.

## Ministry Implications of the Findings

How will the findings inform the purpose of this project? The findings suggest that there are several elements that could be implemented for a new church model that invites and includes people with or affected by mental health conditions. First, because of the importance of friendship and belonging, the word, "includes" should be replaced with "embrace" in the vision statement for the new church model. A new church plant should discern and seek to live this out with a deeper theology of what is means to be human and

living even with disability, illness or suffering. Second, because it will take a blend of church models to create this new one, it is suggested to use aspects of the recovery minded model, the missional model and the table fellowship model. Third, because of the responsibility to educate and be educated to eliminate stigma and marginalization, the new church will participate in the community of Orlando by engaging in events sponsored by mental health organizations and creating new avenues. Fourth, because discipleship is not typically associated with people affected by mental health conditions, this new church model developed will seek to unpack and live out what it means to be a disciple maker in the midst of our weakness and imperfections.

In a phone interview with David Mandeni, Director of the Mental Health Ministry at Saddleback Church, I learned that they are in the midst of developing “communities” for people with mental health conditions. They have recognized the value of people coming alongside one another to help with growth, support and belonging. I shared with him that I am planting a community of faith in Orlando that is seeking to do something similar. One of the things he mentioned is the importance of table fellowship and having a paradigm shift from shame that is associated with mental illness. It may be that we are called to walk alongside someone in the suffering and claiming the incarnational presence of Jesus when they cannot see or hear Jesus on their own. I told Mandeni that we are blending the recovery, missional, holistic, and table fellowship models to create deeper connections and commitment to sharing life with practices of listening, belonging, healing, teaching, truth seeking and educating each other with scripture, sacrament and holistic living. We both acknowledged that a lot has changed in the last twenty years around acceptance of people struggling with addiction, now we hope to see change as it

relates to mental illness; we are just getting started with this concept of community with a holistic ministry approach. As mission is connected to a global context I have been drawn to the holistic model for the church plant I am developing as suggested in the book, *Churches That Make a Difference: Reaching Your Community with Good News and Good Works*.

Churches begin where God is at work by the movement of the Spirit to change minds and wills to the authority of God. Church planters study Christology, Ecclesiology, discipleship methods, and learn the culture in which they are going to plant a church in hopes to have a fruitful church plant. This research project was under the auspice of a "Doctor of Ministry in Church Planting" yet it has occurred to this researcher that the goal of this project is not to "plant," but to create a church model that "distributes" hence, the name of the church being planted in Orlando is called The Distributing Church. It is the hope of the researcher for this project to use the practices of listening, belonging, hospitality, vulnerability, and healing to create a safe, loving, and empowering faith community in whom the healing and hope of Jesus are distributed by the Holy Spirit given through Jesus. It is the hope of the author of this paper to create a new faith community that offers acceptance and love for those who *feel* invisible or uncomfortable in the traditional church.

Many churches are developing external operations such as coffee shops where people can talk openly and casually about faith or whatever. It could be suggested that a piece of this new church model could have a coffee house that benefits people affected be mental health conditions. This operation could implement some of the findings: offering a counseling/resource center with trained staff to provide hope for meaningful, purposeful

lives, creating space for education and eliminating stigma, creating space for developing friendships and developing discipleship and creating space for the practices of listening and healing.

## Limitations of the Study

When this project was started it was my hope to learn about all that was happening in Orlando for people affected by mental illness. I was limited in this study because of the limited response from community organizations and church leaders who were sought for participation in this project. In at least three of the organizations who rejected participation, I tried to push for a reason, but only received abrupt responses like, "I can no longer help you with this project." I sought to glean information for this project from a large number of churches of which I only gained access to information through eight of the twenty-seven churches. Admittedly, some of the church pastors and I could not get our schedules to coordinate and some of the churches were in transition with leadership so they couldn't help at the time. Some of the churches that I approached did not have any type of mental health ministry, so they did not feel their input would be helpful. In conclusion, there were a variety of reasons as to why I was limited to thirteen participants, but I had hoped for a larger pool to draw information.

One last limitation that I would like to mention is the fact that I wish I had a group of people with or affected by mental illness with whom I could ask what practices they would like to see a church include for people like themselves. I feel like I got good information from thirteen leaders, but I would like to have had the ability to gather and interview people who would be involved in the life of the faith community envisioned.

If I were to do this research project again I would have changed the tool for community organization leaders by asking, "What organizations do you think could make an impact on the needs of people with or affected by mental health issues?" I think the focus on Church in the tool I designed might have deterred community organizations from participating. I would also have asked church pastors and leaders less about what the church is doing or not doing, and I would have considered asking more about how they lead people with or affected by mental illness to "follow Jesus"? I tried to keep the survey/questionnaires similar for both community organizations and churches, but I think this might have deterred participation.

## Unexpected Observations

As it relates to the research project itself, it was surprising that so many community organizations did not choose to participate in this project. It was my hope to get more input from organizations about the needs in Orlando. In the completed research tools, I was surprised to discover that church leaders believe there is a shortage of resources in Orlando for low-income housing and funding for those who cannot afford counseling or medical care. Finally, I was surprised in the results of my research that when I talked about people affected by mental illness, the participants automatically addressed it as people "with" a mental illness and no one really talked about how to address the families that are affected. I have concluded that I should have said, "with or affected by mental illness."

## Recommendations

The purpose of this project was to explore practices of church models and community organizations that faithfully invite and include people with or affected by

mental health conditions, in order to develop a new model for downtown Orlando, Florida**.** The findings presented in this chapter provide a framework for the new church model that is being implemented in Orlando as suggested in the purpose statement of this project. There could be more information extrapolated from the research laid out in this project. However, these five findings provide a solid footing for a new church model and hopefully will encourage present and future churches being planted to do more to invite and embrace people living with a mental health condition. In conclusion of this project, there are four recommendations for further exploration.

First, it is recommended that current churches and community organizations in Orlando or in any city, give more effort in deepening an understanding of what it means to be a community. Only thirty-five percent of the population in Orlando is attending church and one in five of the two million living in the greater metropolitan area is living with a mental health condition. There were only eight churches out of the twenty-seven that responded to this research project and four out of the twenty-five community organizations. It is my recommendation that there should be a greater partnership with churches and organizations as it relates to people affected by mental health conditions.

Second, it is recommended that there be a deeper development of a theology of weakness or suffering for the Church. Jesus brought healing through the weakness and suffering of the cross. More could be understood and applied in this context of mental health conditions and the Church. The kingdom of God could be richer for the development of understanding that a person is made in the image of God and needs to be treated as a unique, fearfully wonderfully made person who even in the midst of weakness is valuable and loved. Maybe a module could be developed to help churches

know how to live by embracing people in the margins so that there are no people in the margins. What if the dimension of discipleship was to love and build friendship with people affected by mental illness, not just providing resources to help him or her be "fixed."

Third, it is recommended that a module be developed to help current established churches or those being planted to understand how they could respond to the quarter of the American population who live with a mental health disorder. It would helpful for people to understand that normalcy is a myth as indicated by John Swinton's work. There is work to be done in the healing of our idealized concepts of what humanity should look like so we can celebrate the beauty of who we are in God's eyes.

Fourth, it could helpful to consider creating a module on the practice of healing that sets it apart from the practice of curing. We should consider developing a practice of healing ministry, which includes turning to the healer day by day, seeing the healing of modern medicine as a part of this practice, and the importance it plays to have people surrounding a person with love.

## Postscript

I am appreciative of the support and encouragement offered by the Doctor of Ministry Directors and Church Planting Coaches while I developed this project into an underexplored territory. At times, I have felt like I am a part of a misfit band whom many in American culture would rather send to an island instead of include them in the big picture of the Church, because there is so much stigma, misunderstanding and fear associated with mental illness. Over the past three years, a few people have suggested that the vision for this faith community should be considered as a ministry rather than a

church. Because God set forth the vision for a church in my heart, that is what I have pursued in obedience. As I learned about practices and dimensions to create a new church model, I have had to face the examples of how the church has failed to reach out to the poor, the hopeless, and the ill again and again. Through this project what I have learned could be helpful for churches who have failed to reach people affected by mental health conditions or who do not know how to approach the topic of mental health conditions in their communities or their churches. What I have learned could also provide a much needed piece for the DNA of new churches.

I thought I trusted God, but what I have learned is that God is calling me to trust him more. When we went on the Doctor of Ministry immersion trip to Thailand and then I extended my overseas visit by going to Nepal in the final year of this program, I realized that I struggled with total surrender. I had always taught my children to be mindful about what goes on beyond our immediate context. I have always appreciated learning about various cultures as a means of identifying how our God is creative and multifaceted. Yet, one of the things I have been particularly challenged by is how to share the Gospel in various contexts and how to surrender in the discomfort of what I do not understand. I experienced the heavens opening and the angels descending and ascending as though God was saying, “Trust ME more! What you thought you knew was limited.”

My understanding of this trust even came in seeing people share communion with hibiscus tea and sticky rice in northeastern Thailand. Jesus showed me that he comes in what may seem to be unconventional. I can get hung up on particular aspects of our culture, but I have learned that God is trying to show us his extraordinary nature in the midst of the ordinary parts of a person’s life. It is not the elements or symbols of the

sacraments that we are to live and die by but God's invitation to be reconciled in relationship with him, myself and others. I have deepened my understanding of my deep heritage in Jesus and I have learned that I have freedom to accept all God has given me in this opportunity to join him in doing a new thing.

And finally, I have learned that Jesus is calling me to join in the movement of His Spirit that connects institutional churches, and house churches, and recovery minded churches, and fresh expressions of his people. As I visited various churches in America and in Thailand and Nepal, God has shown be to take various postures to see him, others and myself from various angles. I am humbled by what God has taught me and invited me to experience. What an honor it has been to share the story of how God has worked in my life as I have lived with a mental health condition. It has also been an honor to hear other people's stories and then be invited to pray with them, especially in places like Thailand or Nepal where mental illness is talked about even less than it is in America.

# APPENDICES

Appendix A

## Introduction Letter and Consent Form for Community Organization Leader

Robyn Bishop
1701 East Washington Street
Orlando, Florida 32803
281-734-1979

March 1, 2017

Dear _____________

I am a Doctor of Ministry participant at Asbury Theological Seminary and I am conducting a research project among various churches, as well as community organizations, in downtown Orlando who invite and include people affected by mental illness in order to design a church model that can incorporate and create such practices. I am also a Pastor will a passion to be an advocate for people impacted by mental illness. One in five people will be affected with mental illness in this year so I believe all of us will be impacted in some way.

I have prepared and planed to give two questionnaires in Orlando: one to Pastors of twenty-five churches, as well as one to the leaders of twenty-five different mental health organizations/counseling offices. Upon a general Internet search seeking "mental health organizations in Orlando" or "mental health ministries in Orlando" I selected your organization to request your assistance in this research project. Enclosed with this letter, you will find a consent form, the "**RBB Survey/Questionnaire for Mental Health Community Organization Leaders"** and an addressed, stamped envelope. If you would be willing to participate, please fill out the enclosed consent form, as well as the survey/questionnaire, then return them within two weeks of the date above by regular mail or by email at robyn.bishop@asburyseminary.edu. The information you give on survey/questionnaire will be to be kept confidential if you indicate so on the consent form attached. I understand that the topic of mental illness could be considered a sensitive issue and I do not want to jeopardize any relationships in your church or community. Please also indicate if you would be available for a follow-up interview to discuss the content of questionnaire in more detail. Please note that the data from the questionnaire will be collected and synthesized in a way that will give a blended view in the documentation of this project. I will not use names of leaders or churches and I will give each participant a code name so you will not be identified, unless you choose otherwise. If you choose to participate you can withdraw from the study at any time without penalty. This study poses minimal to no risk to the participant's health.

My hope is that after this research project is completed, I can develop a new church model that connects the church and community organization practices that I have learned about in a way that can bring hope, love and healing to people with or impacted by mental illness. It is also my hope that the information you help me to gather will be of value to your church as well as other churches. If you would like I could provide a copy of my dissertation for you after the project is complete in May of 2018. I realize that your participation is entirely voluntary, and I appreciate your willingness to consider being a part of this project. Feel free to call or write me at any time. Thank you for your help.

Sincerely,

Robyn Bishop

**Consent Form to participate in the "RBB Survey/Questionnaire for Mental Health Community Organization Leaders"**

If you are willing to assist me in this study, please sign and date this form below to indicate your voluntary participation. I understand that the topic of mental illness can be a sensitive topic so you can refuse to respond.

I ___________________________________ (please, print your name) will______ or will not______(please put an X in one of these blanks for will or will not) volunteer to participate in the study described above and so indicate by my signature below:

Your signature: _______________________________________________ Date:______________

I would like to have my name kept confidential: ______yes _______no

I would like to have my organization's name kept confidential: _______yes ______no

I am willing to have a one on one interview with you: _______yes _______ no

I can withdraw from this study at any time without having any penalty: _____yes _____no

Best method of contact (optional):__________________________________________________

## Appendix B

## Introduction Letter and Consent Letter for Church Pastor/Leader

Robyn Bishop
1701 East Washington Street
Orlando, Florida 32803
281-734-1979

March 1, 2017

Dear _____________

I am a Doctor of Ministry participant at Asbury Theological Seminary and I am conducting a research project among various churches, as well as community organizations, in downtown Orlando who invite and include people affected by mental illness in order to design a church model that can incorporate and create such practices. I am also a Pastor with a passion to be an advocate for people impacted by mental illness. One in five people will be affected with mental illness in this year therefore, all of us will be impacted in some way. I have prepared and planed to give two questionnaires in Orlando: one to the lead Pastor of twenty-five churches, as well as one to the leaders of twenty-five different mental health organizations/counseling offices.

Upon a general Internet search seeking "churches in Orlando" or "churches with recovery ministry," I selected your church to request your assistance in this research project. I used two criteria for my selection: first, your church is within seven miles of downtown Orlando and second, your website revealed some sort of care to people struggling with life issues, addiction or mental illness. Enclosed with this letter, you will find a consent form, the "**RBB Survey/Questionnaire for Church Pastors/Leaders,**" and an addressed, stamped envelope. If you would be willing to participate, please fill out the consent form, as well as the questionnaire, then please return them within two weeks of the date above or by email at robyn.bishop@asburyseminary.edu. If you would like for the information you give on the questionnaire to be kept confidential, please indicate this on the consent form enclosed. I will not contact you further as I understand that the topic of mental illness could be considered a sensitive issue and I do not want to jeopardize any relationships in your church or community. If you do not mark the consent form as confidential, then I may contact you for a follow-up interview to discuss the content of questionnaire in more detail. Please note that the data from the questionnaire will be collected and synthesized in a way that will give a blended view in the documentation of this project. I will not use names of leaders or churches and I will give each participant a code name so you will not be identified, unless you choose otherwise. If you choose to participate you can withdraw from the study at any time without penalty. This study poses minimal to no risk to the participant's health.

My hope is that after this research project is completed, I can develop a new church model that connects the church and community organization practices that I have learned about in a way that can bring hope, love and healing to people with or impacted by mental illness. It is also my hope that the information you help me to gather will be of value to your church as well as other churches. If you would like I could provide a copy of my dissertation for you after the project is complete in May of 2018. I realize that your participation is entirely voluntary, and I appreciate your willingness to consider being a part of this project. Feel free to call or write me at any time. Thank you for your help.

Sincerely,

Robyn Bishop

**Consent Form to participate in the "RBB Survey/Questionnaire for Church Pastors/Leaders"**

If you are willing to assist me in this study, please sign and date this form below to indicate your voluntary participation. I understand that the topic of mental illness can be a sensitive topic so you can refuse to respond.

I ___________________________________ (please, print your name) will volunteer to participate in the study described above and so indicate by my signature below:

Your signature: _______________________________________________ Date:______________

I would like to have my name kept confidential: _____yes ______no

I would like to have my church's name kept confidential: _____yes ______no

I am willing to have a one on one interview with you: _____yes ______ no

I realize that I can withdraw from this study at any time without having any penalty: _____yes ______no

Best method of contact (optional):

_________________________________________________________

**Appendix C**

## RBB Survey/Questionnaire for Mental Health Community Organizations

Please indicate where you stand on each of the following six statements by circling a number on each scale of one to five.

1. "The church has a responsibility to talk about and educate people on the topic of mental illness."
   1__________2__________3__________4____________5
   not at all                                                    completely agree

2. "My church is doing a great job of teaching and serving people with or affected by mental illness."
   1__________2__________3__________4____________5
   not at all                                                    completely agree

3. "There is more that can be done for people with mental illness in Orlando."
   1__________2__________3__________4____________5
   not at all                                                    completely agree

4. "Ministry to people with mental illness is different than ministry to people without."
   1__________2__________3__________4____________5
   not at all                                                    completely agree

5. "I would like to see churches do more for people with or affected by mental illness."
   1__________2__________3__________4____________5
   not at all                                                    completely agree

6. "People in Orlando talk openly about mental illness."
   1__________2__________3__________4____________5
   not at all                                                    completely agree

Please answer the questions below. If you need more room please write on the back of this questionnaire.

1. (Optional) Have you or a family member ever struggled with a mental illness? _____ Please, share what type of mental illness and how it has impacted your life or your family?
   ____________________________________________________________
   ____________________________________________________________
2. Do you think there is an opportunity for the local church to do more to support people

with or affected by mental illness? ______ Why or why not?

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

3. In general, people define mental illness in a range of ways. According the Diagnostic Manual of Mental Disorders, there are over 200 types of mental disorders. Please indicate below how many of the following mental illnesses you feel that you understand with a U and which of the following you feel you need to have more education by using the letter E.

   _____Depression _____Schizophrenia ____Bipolar

   _____Substance Addiction _____ Eating Disorder

   ______Suicide

   _____ Anxiety ____ ADHD _____ Autism _____Dementia

   _____ Other

4. Do you think there are dimensions of ministry that are different with people affected by mental illness? ________ How?

   _______________________________________________________________

   _______________________________________________________________

5. Do you think more is needed to be done in the Orlando area to help people with or
   affected by mental illness?

   □ Completely □ Somewhat □ Occasionally □ Adequately □ Never

   What do you suggest can be done?__________________________________________

   _______________________________________________________________

   _______________________________________________________________

   _______________________________________________________________

6. What specific ways will your organization address mental illness in Orlando within the past year?

   _______________________________________________________________

   _______________________________________________________________

7. Please make any further comments you would like to make as it relates to inviting or including people with or affected by mental illness?

   _______________________________________________________________

   _______________________________________________________________

Please attach any information that you would like to share about your organization to share with people with or affected by mental illness.

Name (Optional)________________________________________

Organization (Optional)________________________________________

Phone (Optional)_________________
Email (Optional) _________________________________

**Appendix D**

**RBB Survey/Questionnaire for Church Pastors/Leaders**

Please indicate where you stand on each of the following six statements by circling a number on each scale of one to five.

1. "The church has a responsibility to talk about and educate people on the topic of mental illness."
   1__________2__________3__________4____________5
   not at all completely agree

2. "My church is doing a great job of teaching and serving people with or affected by mental illness."
   1__________2__________3__________4____________5
   not at all completely agree

3. "My church has the resources (access to books, informative material for sermons, contact information for psychiatrists, psychologists, or counselors, etc.) to serve people with or affected by mental illness."
   1__________2__________3__________4____________5
   not at all completely agree

4. "Ministry to people with mental illness is different than ministry to people without."
   1__________2__________3__________4____________5
   not at all completely agree

5. "I would like to see my church do more for people with or affected by mental illness."
   1__________2__________3__________4____________5
   not at all completely agree

6. "People in my church talk openly about mental illness."
   1__________2__________3__________4____________5
   not at all completely agree

Please answer the questions below. If you need more room please write on the back of this questionnaire.

1. (Optional) Have you or a family member ever struggled with a mental illness? _____ Please, share what type of mental illness and how it has impacted your life or your family?
   ____________________________________________________________
   ____________________________________________________________

2. What specific ways (preaching, counseling, support groups, Celebrate Recovery, etc.) has your church addressed the subject of mental illness within the past year?
   ______________________________________________
   ______________________________________________
   ______________________________________________

3. What resources (access to books, informative material for sermons, contact information for psychiatrists, psychologists, or counselors, etc. ) do you think would be helpful to you or your church to help you address mental illness?
   ______________________________________________
   ______________________________________________
   ______________________________________________

4. In general, people define mental illness in a range of ways. According the Diagnostic
   Manual of Mental Disorders, there are over 200 types of mental disorders. Please, indicate below how many of the following mental illnesses you feel that you understand with a U and which of the following you feel you need to have more education by using the letter E.
   _____Depression _____Schizophrenia ____Bipolar

   _____Substance Addiction ____ Eating Disorder ______Suicide

   _____ Anxiety ____ ADHD _____ Autism _____Dementia _____ Other

5. What is different in ministry with people who have a mental illness?
   ______________________________________________
   ______________________________________________

6. What are the best practices your church uses to invite and include people with or impacted by mental illness in the life of your church?
   ______________________________________________
   ______________________________________________

7. What is missing in the Orlando area to help people with or affected by mental illness?
   ______________________________________________
   ______________________________________________

8. Please make any further comments you would like to make as it relates to inviting or including people with or affected by mental illness?
   ______________________________________________

Please attach any information that you would like to share about ministry your church shares with people with or affected by mental illness.

Name (Optional)______________________________________

Church (Optional)________________________________________

Phone (Optional)____________________

Email (Optional) _____________________________

**Appendix E**

Mental Health Community Organization Leaders in Orlando List:

1. Mental Health Association of Central Florida
   1525 East Robinson Street, Orlando 32803

2. NAMI Greater Orlando
   237 Fernwood Boulevard #101, Fern Park 32730

3. Orlando Recovery Center
   600 Lake Ellenor Drive, Orlando 32809

4. Shepherd's Hope Health Center
   101 S. Westmoreland Drive, Orlando 32805

5. Central Florida Behavioral Hospital
   6601 Central Florida Parkway, Orlando 32821

6. LaAmistad Behavorial Health Services
   1650 N Park Avenue, Maitland 32751

7. White Picket Fence Counseling Center
   1345 Clay Street, Winter Park 32789

8. Aspire Health Partners (Lakeside Behavioral Healthcare, Seminole Behavioral Healthcare, and The Center for Drug-Free Living)
   5151 Adamson Street, Suite #200, Orlando 32804

9. University Behavioral Center
   2500 Discovery Drive, Orlando 32826

10. The Center
    946 North Mills Avenue, Orlando 32803

11. The Grove Counseling Center
    111 West Magnolia Avenue, Longwood 32750

12. Solace Counseling
    23 North Summerlin Avenue, Orlando 32801

13. Everyone's Counseling Center
    1600 East Robinson Street, Suite #250, Orlando 32803

14. Total Life Counseling Center
    1950 Lee Road, Suite 115, Winter Park 32789

15. Eirene Counseling Services Inc.
    1802 North Alahaya Trail, Suite #119, Orlando 32826

16. Pathways Drop In Center
    1313 30th Street, Orlando,32805

17. Pasadena Villa Psychiatric Residential Treatment Centers
    216 Pasadena Place, Orlando 32803

18. The Healing House
    417 East Jackson Street, Orlando, 32801

19. First Orlando Counseling Center
    3125 Bruton Blvd, Orlando 32805

20. Charis Counseling Center
    1543 Lake Baldwin Lane b, Orlando 32814

21. HD Counseling
    612 East Colonial Drive, Suite #390, Orlando 32803

22. The Psychology and Counseling Group
    2101 Park Center Drive, Suite 270, Orlando 32835

23. Harmony Mental Health and Behavioral Services
    1601 Park Center Drive, Unit #7, Orlando 32835

24. Orlando Behavioral Center
    10967 Lk Underhill Road, Suite #113

25. The Redeeming Counselor Center
    2562 Rouse Rd, Orlando 32817

**Appendix F**

Churches in Downtown Orlando List:

1. Downtown Baptist Church
   120 East Pine Street, Orlando, FL 32803

2. First Presbyterian Church of Orlando
   106 East Church Street, Orlando, FL 32801

3. Summit Church-Herndon Campus
   735 Herndon Avenue, Orlando, FL 32803

4. First Baptist Orlando
   3000 South John Young Parkway, Orlando, FL 32805

5. Discovery Church- Holden Heights, South Orange
   4400 South Orange Avenue, Orlando, FL 32806

6. Christ Church of Orlando-South of Downtown
   2200 South Orange Avenue, Orlando, FL 32806

7. Celebration Church-Thornton Park
   800 East Robinson Street, Orlando, FL 32801

8. First United Methodist Church
   145 East Jackson Street, Orlando, Fl 32801

9. The Cathedral Church of Saint Luke
   130 North Magnolia, Orlando, Fl 32801

10. H2O Church @ the Abbey
    100 West Livingston Street, PO BOX 780958, Orlando, FL 32878

11. St. James Catholic Church
    215 North Orange Avenue, Orlando, FL 32801

12. St. George Orthodox Church
    24 North Rosalind, Orlando, FL 32801

13. Trinity Lutheran Church and School
    123 East Livingston Street, Orlando, FL 32801

14. Shiloh Baptist Church of Orlando
    604 West Jackson Street, Orlando, FL 32805

15. Reeves Memorial United Methodist Church
    1100 North Fern Creek Avenue, Orlando, FL 32803

16. Winter Park United Methodist Church
    125 North Interlachen Avenue, Winter Park, FL 32879

17. Park Lake Presbyterian Church

300 East Colonial Drive, Orlando, FL 32801

18. College Park UMC
    644 West Princeton Street, Orlando, FL 32804

19. Concord Street Church of Christ
    626 East Concord Street, Orlando, FL 32803

20. Greater Refuge Memorial Church
    526 West Church Street, Orlando, FL 32805

21. St Michael's Episcopal Church
    2499 North Westmoreland Drive, Orlando, FL 32804

22. Audubon Park Covenant Church
    3219 Chelsea Street, Orlando, FL 32803

23. St. John Lutheran Church
    1600 South Orlando Avenue, Winter Park, FL 32789

24. Crosspointe Church
    433 North Mills Avenue, Orlando, FL 32803

25. Central Christian Church (Disciples of Christ)
    250 SW Ivanhoe Boulevard, Orlando, FL 32804

26. Orlando Reformed Presbyterian Church
    324 East Livingston Street, Orlando, FL 32801

27. Church in the Son
    4484 North John Young Parkway, Orlando, FL 32804

## Works Cited

Abraham, Reggie. "Mental Illness and the Ministry of the Local Church." *Pastoral Psychology* 63.5-6 (2013): 525–535. Web.

Addison, Steve. *What Jesus Started: Joining the Movement, Changing the World*. Downers Grove, IL: InterVarsity Press, 2012. Print.

Alcoholics Anonymous. < https://www.aa.org > Alcoholics *Anonymous World Services, Inc.,* (2018). Web. 31 Mar. 2018

---. *Alcoholics Anonymous: The Story of How Many Thousands of Mean and Women Have Recovered from Alcoholism.* New York, NY: Alcoholics Anonymous World Services, Inc., 2011. Print.

Anakwenze, Ujunwa, and Daniyal Zuberi. "Mental Health and Poverty in the Inner City." *Health and Social Work* 38.3 (2013): 147–157. Web.

Andrade, Soria. *"Mental Health and Public Health Interventions"* <https://pha.berkeley.edu/2017/11/ 05/mental-health-and-public-health-interventions/> (November 5, 2017) The Public Health Advocate. Web. 15 July 2018.

Barth, Cindy. "Florida about Average for Church Attendance." *Orlando Business Journal.* Biz Journals, 20 Feb. 2015. Web. 8 April 2018.

Benz, Jonathan, and Kristina Robb-Dover. *The Recovery-Minded Church: Loveing and Ministering to People with Addiction.* Downers Grove, IL: IVP Books, 2016. Print.

Bosch, David J. *Transforming Mission: Paradigm Shifts in the Theology of Mission*. Maryknoll, NY: Orbis Books, 1991. Print.

Brown, Brene. *The Gifts of Imperfection*. Center City, MN: Hazelden, 2010. Print.

Carey, Benedict. "Are Mass Murderers Insane? Usually Not, Researchers Say." *The New York Times*. N.p. 8 November 2017. Web. 13 July 2018.

Carey, Benedict. "Defying Prevention Efforts, Suicide Rates Are Climbing Across the Nation." *The New York Times.* N.p. 7 June 2018. Web. 15 July 2018.

Christenson, Jen. *"Trump's Language on School Shooter's Mental Health Could be Harmful, Experts Say*"< https://www.cnn.com/2018/02/22/health/trump-mental-illness-comments-bn/index.html > CNN (February 22, 2018). Web. Accessed July 13, 2018.

City of Orlando. http://www.cityoforlando.net/visitors/ N.d.Web. 13 July 2018.

Collier, Bryan. *The God-To Church: Post MegaChurch Growth.* Nashville, TN: Abingdon Press, 2013. Kindle.

Corbett, Steve and Brian Fikkert, *When Helping Hurts: How to Alleviate Poverty Without Hurting the Poor and Yourself.* Chicago, IL: Moody Publishers. 2009. Print.

Creswell, John W., and J. David Creswell. *Research Design: Qualitative, Quantitative, and Mixed Method Approaches*, 5th Ed. Thousand Oaks, CA: Sage Publications, 2018. Print.

Doyle, Alan, Julius Lanoil, and Kenneth J. Dudek. *Fountain House: Creating Community in Mental Health Practice*. New York, NY: Columbia University Press, 2013. Kindle.

*Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. Arlington, VA: American Psychiatric Association, 2013. Print.

Ferguson, Dave and Jon Ferguson. *Exponential: How You and Your Friends Can Start a Missional Church Movement*. Grand Rapids, MI: Zondervan, 2010. Print.

Fosner, Verlon. *Welcome to Dinner Church*. Franklin, TN: Seedbed Publishing, 2017. Print.

Foster, Richard J. *Celebrations of Discipline: The Path to Spiritual Growth.* San Francisco, CA: HarperCollins Publishers, 1978. Print

Fresh Expressions. <https://freshexpressionsus.org/about/#what> Web. 2 April 2018.

Frost, Michael. *Surprise the World: The Five Habits of Highly Missional People.* Colorado Springs, CO: NavPress, 2016. Print.

Garrison, David. *Church Planting Movements: How God Is Redeeming a Lost World*. Midlothian, VA: WIGTake Resources, 2004. Print.

Greene-McCreight, Kathryn. *Darkness Is My Only Companion: A Christian Response to Mental Illness.* Grand Rapids, MI: Brazos Press, 2015. Print.

Guder, Darrell. *Missional Church: A Vision for the Sending of the Church in North America*. Grand Rapids, MI: Eerdmans, 1998. Print.

Hellerman, Joseph. *When the Church Was a Family: Recapturing Jesus' Vision for Authentic Christian Community*. Nashville, TN: B&H Academic, 2009. Print.

Herships, Jerry. *Last Call: From Serving Drinks to Serving Jesus*. Louisville, KY: Westminster John Knox, 2015. Print.

Hirsch, Alan. *The Forgotten Ways: Reactivating the Missional Church*. Grand Rapids, MI: Brazos Press, 2006. Print.

Hope for Mental Health. "Our Purpose." *Hope for Mental Health.* Saddleback Christian Church, n.d. Web. 26 March 2018

Johnson, Eric. *Psychology & Christianity Five Views*. Downers Grove, IL: IVP Academic, 2010. Print.

Jones, Barry. "The Dinner Table as a Place of Connection, Brokenness and Blessing." *DTS Magazine*. (2015) Web. 10 April 2018.

Kehoe, Nancy. *Wrestling with Our Inner Angels: Faith, Mental Illness, and the Journey to Wholeness*. San Francisco, CA: Jossey-Bass, 2009. Print.

Keck, Leander Sr. Ed. The New Interpreter's Bible: General Articles & Introduction, Commentary, & Reflections for Each Book of the Bible Including the Apocryphal/Deuterocanonical Books. Vol VIII. Nashville, TN:Abingdon Press, 1995. p. Print.

Kiesel, Laura. "Don't Blame Mental Illness for Mass Shootings; Blame Men" <https://www.politico.com/magazine/story/2018/01/17/gun-violence-masculinity-216321> PoliticoMagazine (January 13, 2018). Web. June 17, 2018.

Klibanoff, Eleanor. "House Churches Swap Steeples for Sofas, and say They've Never Been Closer." *All Things Consider.* National Public Radio, Inc. (22 Feb. 2015) Web. 26 March 2018.

Koenig, Harold G. "To Believe or Not to Believe: The Role of Faith in Treating Mental Illness and Preventing Suicide." *Christian Counseling Today* 21. No. 2 (2016): 28–32. Print.

Lee, Morgan. "What Made Mental Illness a 'Sin'? Paganism And How Psychiatry and Psychology Came to be Seen as Anti-God" *Christianity Today.* (15 February 2018). Web. 18 February 2018.

LifeWay Research. "Study of Acute Mental Illness and Christian Faith." Nashville, TN: (2014): 1–40 (PDF). Web . 17 April 2018.

McDaniel, Debbie. "7 Bible figures who Struggled with Depression." *Crosswalk*. Salem Web Network, 5 June 2017. Web. 21 March 2018.

McLeod, Susan. "Maslow's Hierarchy of Needs." Simply Psychology, May 2018. Web. 15 Feb. 2018.

Menlo Park. "Starting a Mental Health Support Group at Your Church." *Menlo Church*. <https://menlo.church/starting-a-mental-health-support-group-at-your-church> (2018) Web. 18 March 2018.

Minatrea, Milfred. *Shaped by God's Heart: The Passion and Practices of Missional Churches*. San Francisco CA: Jossey-Bass, 2004. Print.

Murray, Stuart. *Church Planting: Laying Foundations*. Scottsdale, PA: Herald Press, 2001. Kindle.

Murren, Doug. *Churches That Heal: Becoming a Church That Mends Broken Hearts and Restores Shattered Lives*. West Monroe, LA: Howard Pub., 1999. Print.

Moynagh, Michael. *Church for Every Context: An Introduction to Theology and Practice*. London, England: SCM Press, 2012. Kindle.

NAMI. < https://www/nami/org/Learn-More/Mental-Health-Conditions/Related-Conditions/SUal-Diagnosis > *National Alliance of Mental Illness.* N.d. Web. 22 March 2018.

Newbigin, Lesslie. *The Open Secret: An Introduction to the Theology of Mission*. Grand Rapids MI: Eerdmans, 1995. Print.

Newport, Frank. Frequent “Church Attendance Highest in Utah, Lowest in Vermont.” *Gallup Social and Policy Issues,* 17 Feb. 2015 Web. 22 April 2018.

Nouwen, Henri. *The Wounded Healer: Ministry in Contemporary Society*. New York, NY: Image Books, 1972. Print.

Ott, Craig and Gene Wilson. *Global Church Planting: Biblical Principles and Best Practices for Multiplication*. Grand Rapids, MI: Baker Academic, 2011. Print.

Padilla, Joe. “What the Bible Says About Dealing with Depression and Anxiety.” *Mental Health Grace Alliance*. Blog (18 Dec. 2017). 2015. Web. 1 Mar. 2016.

Payne, Jervis. *Apostolic Church Planting: Birthing New Churches from New Believers*. Downers Grove, IL: IVP Books, 2015. Print.

---. *Discovering Church Planting: An Introduction to the Whats, Whys, and Hows of Global Church Planting*. Colorado Springs, CO: Paternoster Publishing, 2009. Print.

“Quick Facts: Orlando city, Florida.” US Census Bureau. N.d. Web. 31 March 2018.

Ruether, Rosemary. *Many Forms of Madness: A Family’s Struggle with Mental Illness and the Mental Health System*. Minneapolis: Fortress Press, 2010. Print.

Ryan, Dale. “The Christian Recovery Movement: a Brief Introduction.” National Association for Christian Recovery. N.d. Web. 2 April 2018.

Sakenfeld, Katharine Doob, Gen Ed. “Disease.” *The New Interpreter’s Dictionary of The Bible: D-H Vol 2.* Nashville, TN: Abingdon Press, 2008. 135-140. Print.

---. “Madness.” *The New Interpreter’s Dictionary of the Bible: I-Ma Vol 3.* Nashville, TN: Abingdon Press, 2008. 765-766. Print.

Sensing, Tim. *Qualitative Research: A Multi-Methods Approach to Projects for Doctor of Ministry Theses.* Eugene, OR: Wipf and Stock Publishers. 2011. Print.

Simpson, Amy. *Troubled Minds: Mental Illness and the Church’s Mission*. Downers Grove, IL: IVP Books, 2013. Print.

---. “Supporting Families Living with Mental Illness.” *The Covenant Quarterly* Vol. 73 Nos. 3/4 (August/November 2015). p. 40-53. Print. 13 April 2017.

Simson, Wolfgang. *Houses that Change the World: The Return of the House Churches.* Waynesboro, GA: Paternoster Publishing, 2001. Print.

Stanford, Matthew S. “Rethinking Mental Healthcare: How the Church Can Transform a Broken System.” *Christian Counseling Today* Vol 21 No (2016). p. 22–26. Print.

---. *Grace for the Afflicted: Viewing Mental Illness Through the Eyes of Faith*. Colorado Springs, CO: Paternoster, 2008. Print.

---. *The Biology of Sin: Grace, Hope and Healing for Those Who Feel Trapped*. Colorado Springs CO: Biblica, 2010. Print.

Stetzer, Ed. *Planting Missional Churches*. Nashville, TN: Broadman & Holman, 2006. Print.

---. “The Church and Mental Health: What Do the Numbers Tell Us?” *Christian Counseling Today* Vol 21 No (2016): p 34–38. Print.

Swanson, Liz and Teresa McBean. *Bridges to Grace: Innovative Approaches to Recovery* Ministry. Grand Rapids, MI: Zondervan, 2011. Print.

Sweet, Leonard. *From Tablet to Table: Where Community is Found and Identity is Formed.* Colorado Springs, CO: NavPress, 2014. Print.

Swinton, John. *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems*. Nashville, TN: Abingdon Press, 2000. Print.

---. “From Inclusion to Belonging: A Practical Theology of Community, Disability and Humanness.” *Journal of Religion, Disability and Health*. 16.2 (2012). p. 172-190. Print.

---, and Jean Vanier. Mental Health: The Inclusive Church Resource. London, England: Darton, Longman and Todd, Ltd., 2014. Print.

Stott, John R.W. *The Cross of Christ.* Downers Grove, IL: IVP 2006. Print.

The National Institute of Mental Health. "Substance Use and Mental Health" *The National Institute of Mental Health*. (May 2016) Web. 4 March 2018.

The United Methodist Church. *"Apostle's Creed. Traditional and Ecumenical Versions." The United Methodist Church.* (2018).Web. 25 January 2018.

Thompson, Colleen Swindol. "Transforming the Soul—What we Didn't Learn in Seminary: An Interview with Church Swindoll and Steve Fischer." *Reframing Ministries.* 6 Jan. 2015. Web. 4 March 2018.

Van Gelder, Craig. *The Missional Church in Perspective: Mapping Trends and Shaping the Conversation*. Grand Rapids, MI: Baker Academic, 2011. Print.

Vanier, Jean. *Becoming Human*. Mahwah, NJ: Paulist Press, 1998. Print.

---. *The Heart of L'Arche: A Spirituality for Every Day*. Toronto, Canada: Novalis, 2012. Print.

Willis, Dustin. "Life in Community: *Joining Together to Display the Gospel*. Chicago, IL: Moody Publishers, 2015. Print.

Wright. N.T. *John for Everyone Part 1:Chapters 1-10*. Louisville, KY: Westminster John Knox Press. 2002. Print.

---. *Luke for Everyone.* Louisville, KY: Westminster John Knox Press. 2002. Print.

**Works Consulted**

Altrogge, Stephen. "Is Mental Illness Actually Biblical?" *Bible Study Tools*. N.p., n.d. Web. 22 Mar. 2016.

Albers, Robert. *Ministry with Persons with Mental Illness and Their Families*. Minneapolis, MN: Fortress Press, 2012. Print.

Audette, Andy. "A Church Planting Journey: What I Saw Will Stick with Me for the Rest of My Life." *Missio Apostolica* 6 (2015): 125–130. Print.

Bakke, Raymond. *The Urban Christian: Effective Ministry in Today's Urban World*. Downers Grove, IL: InterVarsity Press, 1987. Print.

Bazeley, Pat. *Qualitative Data Analysis: Practical Strategies.* Thousand Oaks, CA: Sage Publications, 2013. Kindle.

Billings, J. Todd. "What Makes a Church Missional? Freedom from Cultural Captivity." *Christianity Today*. 5 March 2008. Web. 4 Mar. 2016.

Boers, Arthur. "What Henri Nouwen Found at Daybreak." *Christianity Today*. 3 Oct. 1994. Web. 10 Mar. 2016.

Breedt, Jacob J, and Cornelius J P Niemandt. "Relational Leadership and the Missional Church." *Verbum et Ecclesia* 34.1 (2013): 8–9. Web.

Cloud, Ph.D., Henry. "Leading the Church into Mental Health." *Christian Counseling Today* 21.No. 2 (2016): 82–83. Print.

Close, Jessie. *Resilience: Two Sisters and A Story of Mental Illness*. New York: Grand Central Publishing, 2015.

Conn, Harvie M. *Planting and Growing Urban Churches: From Dream to Reality*. Grand Rapids, MI: Baker, 2002. Print.

Corrigan, Psy.D., Patrick D. "Challenging the Stigma of Mental Illness: Different Agendas, Different Goals." *Psychiatric Services: A Journey of the American* 66 (2015): 1347–1349. Web.

E Team. "Faith, Hope, and Love: The Church as Salt and Light." *Christian Counseling Today* 21.No 21 (2016): 12–13. Print.

Effa, Allan. "Missional Voices down under A Canadian Response to the Missiology of Michael Frost and Alan Hirsch." *Missiology: An International Review* 38.1 (2010): 61–73. Web.

Fuder, John. *Neighborhood Mapping: How to Make Your Church Invaluable to the Community*. Chicago: Moody Publishers, 2014. Print.

Garland, Diana R. "The Effects of Mental Illness on Families within Faith Communities." *Mental Health, Religion & Culture* 15.no. 3(2012): 301–313. Web. 24 Feb. 2016.

Gibson, Michaela. "'From Slavery to Freedom' Redeemed: Tupelo Pastor Shares His Journey through Recovery Ministry." *Daily Journal.* (14 April 2017). Web. April 14, 2014.

Griffith, James L., Michael T. Compton, and Neely Myers, "How Can Community Religious Groups Aid recovery for Individuals with Psychotic Illnesses?" *Springer Science and Business*. (2016). 275-280. Print.

Hammond, Kim and Darren Cronshaw. *Sentness: Six Postures of Missional Christians*. Downers Grove, IL: InterVarsity Press, 2014. Print.

Harmon, Angela. "Mental Health Stigma." *Salem Press Encyclopedia of Health*. (2015). Web. 2 Mar. 2016.

Harney, Kevin. *Organic Outreach for Churches: Infusing Evangelistic Passion into Your Congregation*. Grand Rapids, MI: Zondervan, 2011. Print.

Hunter, Joel. *Church Distributed: How the Church Can Thrive in the Coming Era of Connection*. Longwood, FL: Distributed Church Press, 2007. Print.

Kwok-on, David et al. "The Place of Church Planting in Mission: Towards a Theological Framework." *Anglican Theological Review* 92.1 (2009). 316–331. Web.

Lyles, M.D., Michael R. "The Church and Mental Illness." *Christian Counseling Today* 21.No. 2 (2016). 78. Print.

---. "Is Your Church Healthy for People with Mental Illness? Christianity Today. (October 2017). Web. 9 July 2018.

Marshall, Glen. "A Missional Ecclesiology for the 21st Century." *Journal of European Baptists,* July (2013): 5–22. Print.

Moodle, Jenny Taylor. "BWW Reviews: WOMEN IN THE PIT Is An Astute, Emotional Ride At The Ensemble Theatre." *Broadwayworld.* 6 Oct. 2014. Print.

Moon, M.Div. Ph. D., Gary W. "Finding God in the Midst of Pain and Suffering." *Christian Counseling Today* 21.No. 2 (2016): 76–77. Print.

Page, Frank S. "Crossing the Threshold: When Suicide Hits the Family of God." *Christian Counseling Today* 21.No. 2 (2016). 16–20. Print.

Peters, Ronald. *Urban Ministry: An Introduction*. Nashville, TN: Abingdon Press, 2007. Print.

Prebble, Edward. "Missional Church: More a Theological (Re) Discovery, Less a Strategy for Parish Development." *Mission Theology in the Anglican Communion* <http://www.missiontheologyanglican.org/article/missional-church-more-a-theological-rediscovery-less-a-strategy-for-parish-development/> (23 Sept. 2016). Web. 23 January 2018.

Reimer, Johannes. "Empowering Church Planters. Which Training System ? Johannes R Eim Er." *Evangelical Review of Theology* (2016): 70–81. Print.

Resane, K. Thomas. "Leadership for the Church: The Shepherd Model." *HTS Teologiese Studies / Theological Studies* 70.1 (2014): 1–7. Web.

Richardson, Rick. "Emerging Missional Movements : An Overview and Assessment of Some Implications for Mission ( S )." July (2013): n.p. Print.

Rogers, Anne. *A Sociology of Mental Health and Illness*. N.p., 2014. Web. 11 Mar. 2016.

Schuster, Sarah. "33 Things About Mental Illness No One Talks About." *The Mighty.* 19 Feb. 2016 Web. 1 Mar. 2016.

Servan-Schreiber, David. *The Instinct to Heal: Curing Stress, Anxiety, and Depression Without Drugs and Without Talk Therapy*. Emmaus PA: St. Martin's Press, 2004. Print.

Shaw, Perry W. H. "The Missional-Ecclesial Leadership Vision of the Early Church." *Evangelical Review of Theology* 37.2 (2013). 131–139. Print.

Simpson, Amy. "Church for Troubled Minds." *Prism* Vol 20. No. 4. (2013). 50-51. Print

Slaughter, Michael. *Unlearning Church*. Nashville, TN: Abingdon Press, 2008. Print.

Smietana, Bob. "Tackling Stigma of Mental Illness." *Christian Century* (2013). 14–16. Print

---. "Mental Illness Remains Taboo Topic for Many Pastors." *LifeWay Research* (22 Sep. 2014). Web. 31 Mar. 2016.

Spellers, Stephanie. "The Church Awake: Becoming the Missional People of God." *Anglican Theological Review* (2010): 61–62. Web.

Stanford, Matthew S., and Kandace R. McAlister. "Perceptions of Serious Mental Illness in the Local Church." *Journal of Religion, Disability & Health* 12.2 (2008): 144–153. Web.

Stanley, Andy. *Deep & Wide: Creating Churches Unchurched People Love to Attend*. Grand Rapids, MI: Zondervan, 2012. Print.

Stetzer, Ed. "A New Approach to Mental Illness in the Church." *Christianity Today*. (2015). Web. 31 Mar. 2016.

Tan, Siang-Yang. "Theoretical Issues in the Relationship Between Psychology and Religion: Some Comments on Reber, Nelson, Slife and Whoolery, and

Richardson." *Journal of Psychology and Theology* 34.3 (1 September 2006). 260–265. Web. 7 May 2018.

Tino, James, and Brink, Paul. "A Model for Urban Church Planting – The First Phase: From Preliminary Investigation to First Worship Service." *Missio Apostolica* (1999): 40–46. Print.

US Census Bureau, Demographic Internet Staff. "US Census Bureau Poverty Main Page." Web. 23 Mar. 2016.

Viola, Frank. "3 Christian Responses to Mental Illness: Which One Is Most Biblical?" N.p., n.d. Web. 22 Mar. 2016.

Warren, Rick and Kay Warren. "Rick Warren: Churches Must Do More to Address Mental Illness." *Time.* (27 March 2014). Web. 1 Mar. 2016.

Wise, Dave. "Companionship Aids in Mental Illness and Faith Recovery." *Pathways to Promise.* (2 Dec. 2015). Web. 29 Feb. 2016.

Zaimov, Stoyan. "Kay Warren Says, America's Mental Health System Is Broken, the Church Must Embrace Millions Suffering from Mental Illness." *Christian Post*. (28 Aug. 2015). Web. 1 Mar. 2016.