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Benefits of Mental Illness Training Programs in the Church

Submitted to Dr. Teresa Duez

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by

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Thesis Project Approval Sheet

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THE DOCTOR OF MINISTRY THESIS PROJECT ABSTRACT
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The church consists of God's people. It is the assembly of believers in Jesus Christ. The physical buildings facilitate the fellowship, worship, and ministry of God's people. According to Matthew 10:8, one of the mandates given to the body of Christ is to heal the sick. Mental illness of any form is an illness that requires proper care and attention. And we know Jesus came to comfort us in all our afflictions which include mental illness; most churches do not address this topic due to stigma. There is often a greater shame regarding this illness within the church than outside, forgetting that the church is called to extend grace and mercy, not shame. Pastors need more assistance and preparation for dealing with mental-health crises. This study was based on fifteen teenagers' anonymous mental health survey in Arise and Shine International Ministries. The survey provided an insight into what the teenagers were going through, unknowingly to the church. After which, a three-week training for three hours on mental health awareness took place with fifteen leaders via Zoom. This survey revealed that the church community would benefit from integrating mental illness training in the church. Based on these results, this research recommends incorporating faith-based mental health awareness lessons into the church leadership training.

Abstract length: 211 words.

Keywords: *Stigma, Mental illness, faith-based, training in the church, mental health awareness*

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Abbreviations

ASIM	*Arise and Shine International Ministries*
MHFA	*Mental Health First Aid*
COVID- 19	*Coronavirus*

CHAPTER 1: INTRODUCTION

Introduction

Mental illness is a growing topic, becoming more common among teenagers and young adults today. Despite the plethora of research regarding mental health disorders, stigma towards those struggling with this illness persists. Mental disorders account for one of the most suffered diseases in all societies. It is also projected that mental disorders will increase from year to year.[1] There needs to be more awareness and treatment regarding this, beginning in the church. Many people with mental health illnesses feel more comfortable seeking help from churches than trained professionals. The church is a sanctuary for healing and should be equipped to assist the sick. The church can increase the understanding of mental illness, eliminate stigma, and identify and respond to the various individuals undergoing a mental health crisis. In Mark 2:16-17 (New King James Version), the Pharisees saw Jesus eating with the sinners, the broken, the ones who were hurting, and they questioned Him. "When Jesus heard it, He said to them, "Those who are well have no need of a physician, but those who are sick."[2] This chapter focuses on Arise and Shine International Ministries' ministry content, the problem presented with the church, the purpose statement, the basic assumption, definitions, limitations, delimitations, and the thesis statement.

Ministry Context

Arise and Shine International Ministries (ASIM) is a multi-racial, multi-cultural and multi-ethnic congregation non-denominational Pentecostal church that began in December 2003

[1] Morgan, J. Amy, Ross, Anna, Nicola, J. Reavley. "*Systematic review and meta-analysis of Mental Health First Aid training: Effects on knowledge, stigma, and helping behavior."* Plos one 18, no. 5 (2018) 2.

[2] Mark 2:16-17

in Dallas, Texas. ASIM's first Sunday service was held on the 28th of December 2003 at Holiday Inn in Irving, Texas. From there, ASIM transitioned to the Convention Plaza in February 2004. After three Sunday services, they found a permanent worship place in March 2004 at 3501 North MacArthur Blvd in the MacArthur Commons in Irving, Texas. While in the MacArthur Commons, the church established a unique program titled "Breakthrough Night." This program is held every 3rd Friday of the month and has generated many testimonies for members and visitors alike. In April of 2011, the ministry moved to their new home in Bedford, Texas, where it currently resides.[3]

The founders of ASIM are Bishop Nosa Onaiwu and Pastor Adesuwa Onaiwu. Bishop Dr. Nosa Onaiwu is the visionary and Bishop of Arise & Shine International Ministries. He is a vibrant Spirit-filled leader commissioned by God to win souls, deliver, teach, and equip them to fulfill their divine destinies. He preaches God's Word with the boldness of faith, without fear or compromise. He is a man of prayer and believes that prayer changes things, that with prayer, anyone can rewrite their history, move the hand of God in any situation to bring a change. Bishop Onaiwu holds a Doctorate Degree in Ministry and a master's degree in Christian Education. He was initially an artist and worked as a Banknote Engraver for ten years before his ministry call. On the 16th of April 2016, he was consecrated as a Bishop by Archbishop Kirby Clements and Archbishop Margaret Benson-Idahosa. Bishop Onaiwu is blessed with five children—Blessing, Blessed, Bless, Blessedness, and Grace and one grand-daughter— Sharon.[4]

[3] Arise and Shine International Ministries, "About Us" accessed March 26th, 2021, https://www.asimglobal.org/about-us.html.

[4] Arise and Shine International Ministries, "Our Pastors" accessed March 26th, 2021 https://www.asimglobal.org/bishop-nosa-onaiwu.html.

The co-founder of ASIM was Pastor Dr. Adesuwa Onaiwu. She was a counselor, a teacher, an intercessor, and a prophetess. She was called and appointed by God to preach the good news of Jesus Christ to those who are weary, lost, and without hope. Her testimonies and various encounters with Jesus Christ showed her genuine love for the Lord and His grace upon her. She was the founder of Daughters of Destiny International, a women's ministry wing of ASIM. She also hosted and organized women's breakfast meetings, annual Women's Conferences, and Pastor's Wives Conference. She was passionate about mentoring married and single ladies to discover who they are in Christ. She also empowered them with God's Word to fulfill their divine destinies. Pastor Adesuwa held a Doctorate Degree in Christian Counseling from Friends International Christian University, California. She was an attorney by profession. Pastor Adesuwa went to be with her Lord and Savior, Jesus Christ, on Thursday, the 28th of July 2016 and is now part of the Great Cloud of Witnesses (Hebrews 12:1).[5]

The vision of ASIM is to rescue the lost and transform them to reign as kings and priests on earth. They were winning lost souls for Christ, training and empowering them with the infallible Word of God to fulfill their God-given destiny and preparing them to make heaven. The church is founded on biblical principles and is committed to: Preach the Word of faith to the poor in spirit, bring deliverance to the oppressed, heal the brokenhearted, rebuild the destinies of those that have been fragmented, help men fulfill their God-given dreams, and build prayer intercessors for nations.[6]

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[5] Arise and Shine International Ministries, "Our Pastors" accessed March 26th, 2021 https://www.asimglobal.org/pastor-adesuwa-onaiwu.html.

[6] Arise and Shine International Ministries, "Mission/ Vision" accessed March 26th, 2021 https://www.asimglobal.org/missionvision.html.

The philosophy of ASIM centers on the Bible. ASIM believes that the Bible is the inspired Word of God to men, the infallible rule of faith and conduct, and is superior to conscience and reason, but not contrary to reason. ASIM believes in the being and unity of God--Father, Son, and Holy Spirit. ASIM believes in believers' personal salvation through the shed blood of Jesus Christ. ASIM believes that all who by faith receive Jesus Christ as Lord and Savior and who confess Him as Lord are born again of the Holy Spirit and thereby become children of God. ASIM believes in the Lord's Supper, a sacred ceremony symbolizing our Lord Jesus's sacrifice. ASIM believes in the Second coming of the Lord Jesus Christ. The resurrection of those who have fallen asleep in Christ and their translation, together with those who are alive and remain unto the coming of the Lord, is the imminent and blessed hope of the church. ASIM believes in believers' water baptism by immersion as an outward expression of their death to sin and resurrection to a new life in Christ Jesus. ASIM believes in the Holy Spirit's baptism with the scriptural evidence of speaking with other tongues as the Spirit of God gave them utterance as an experience after salvation. Finally, ASIM believes in deliverance from sicknesses, bondages, and other oppressions of the devil as provided in the atonement and is the privilege of all believers.[7]

Sunday Services at ASIM are held at 10 am, and 11:30 am. Midweek prayer and teaching services are held on Tuesdays at 7:30 pm. Bible study is held via Zoom on Wednesdays at 8 pm. Intercessory prayers are held on Thursdays and Saturdays at 7 pm. Every third Friday of the month, ASIM has a prayer vigil at 10:30 pm. Finally, every last Friday of the month, ASIM hosts Worship Night for teens and young adults.

[7] Arise and Shine International Ministries, "What We Believe" accessed March 26th, 2021 https://www.asimglobal.org/what-we-believe.html.

The men's department in ASIM called Men of Dominion comprises honor after God's heart. Founded in 2006, this is a group of men in action, building lives and destinies. Their objective is to build men's lives spiritually, financially, family, health, and recreation to advance God's kingdom on the earth through our Lord Jesus Christ. Their vision is to minister to men intellectually, emotionally, socially, effectively, and spiritually. To identify and meet men's needs in the church and the community. To foster and develop meaningful relationships and bring positive changes in men's lives.[8]

The women's ministry, called Daughters of Destiny, consists of virtuous women, wives, mothers, and spinsters who love Jesus passionately. This ministry was founded in 2006 to mentor women and empower them to become achievers in life and fulfill their God-given destinies. Their task is to impact women within the church and the community to arise and shine by the Holy Spirit's power. Their goal is to empower women with the Word of God that never fails. To teach women to pray and enjoy intimacy with God daily. To build intercessors to stand in the gap for their families, the church, and the nation. To reach out to one another in love and fellowship for the kingdom's advancement. To heal hurting women and move them away from the past into God's colorful destiny for them. To set the captives free from physical, spiritual, and emotional bondage.[9]

The children's ministry desires to introduce the children to Jesus Christ and encourage them to develop a personal relationship with Him through prayer and a firm understanding of the foundational biblical truths. The teachers break down the Word of God into age-appropriate

[8] Arise and Shine International Ministries, "Men's Ministry" accessed March 26th, 2021 https://www.asimglobal.org/mens-ministry.html.

[9] Arise and Shine International Ministries, "Women's Ministry" accessed March 26th, 2021 https://www.asimglobal.org/womens-ministry.html.

levels to instill godly character, biblical foundations, and principles of Christ into their hearts and minds to equip them to deal with peer pressure, family situations, or temptations they encounter in life. The children's ministry is filled with trained teachers dedicated to creating an interactive environment for them. The goal is for children to grow in the complete understanding of who they are in God and what they are called to do on earth.[10]

The young adults/ teens ministry consists of teenagers (13-19-year-olds) passionate for Jesus and desire to know Him and make Him known. The youths are on fire for the Lord and love to serve in the ministry. They have hosted several phenomenal youth events and continue to spread the Word about the kingdom of God effectively. Every month they host a worship night secession, which opens the doors for individuals to come as they are and worship. But like many youths today, 80% of them struggle with various types of mental health issues. During COVID-19, there was a spike of mental problems such as depression, suicide, anxiety, etc., within the ASIM teens. Many teenagers stayed in ASIM at home 24/7 and hardly came out; now, they find it challenging to come into reality. They are failing one or more of their classes, building little to no study habits, poor eating habits, and unhealthy weight gain. The majority of the parents are not at home due to their work schedules. The teenagers do not reach out for adequate mental help for various reasons, but they feel more comfortable talking with their peers. There are four youth pastors in the church, and the teens still do not feel comfortable talking about their struggles. The church creates platforms for the teens to mingle and bond, but most of the time, not all of them show up. These teenagers know God's Word and realize they have mental struggles. ASIM should create a center to address their mental struggles in the church.

[10] Arise and Shine International Ministries, "Children's Ministry" accessed March 26th, 2021 https://www.asimglobal.org/childrens-ministry.html.

Problem Presented

The problem is that Arise and Shine teenagers struggling with mental health are not receiving adequate counseling or support due to cultural stigma. It is a known fact that depression is one of the leading causes of disability among teenagers globally.[11] Mental illness is common in teenagers; many types of this illness are treatable if they receive sufficient support. There are also programs and training geared to support individuals. However, despite the plethora of courses available for mental illness, teenagers in Arise and Shine battle this occasionally.

Some teenagers and young adults struggle silently and refuse to open up about their illness due to stigma. Teenagers and young adults actively serve in the ministry but battle depression and anxiety. ASIM encourages everyone to find a place in the ministry to operate, no matter their age, but some teenagers need additional assistance. There is a need to strike a balance between serving and being served. Some teenagers appear to be living their best life, but they cry out for help inwardly. The church must pay attention to these specific individuals and design initiatives to help each one.

Purpose Statement

The purpose for this DMIN action research thesis is to study how adequate counseling can drastically transform teenagers struggling with mental illness. While other variables influence this result, training and counseling leaders to support the teenagers during a challenging time is the first step. Creating a counseling center filled with well-trained and qualified staff prepares the church more. The training course will prepare the leaders to identify

[11] Michaela C Pascoe, et al. "Exercise interventions for mental disorders in young people: a scoping review." B.M.J. Open Sport & Exercise Medicine, (2019) 1.

and respond to signs that a person may have a mental illness or distress. Rather than being overlooked, the training would address and eventually eliminate the stigma around mental illness. If the church must send its teenagers out into the world, the church should meet their mental health needs. The church can better understand these realities that indeed exist among our children and teenagers to have training.

The church benefits from this by equipping its congregation with deep knowledge of mental illness, eliminating tradition and stigma. It opens the doors for people to receive proper healing from diverse mental diseases. The result is that teenagers in ASIM will become mentally stable, and leaders will render assistance to those in need. It also brings healing and restoration to individuals and families broken in the process. Talking about mental illness from the pulpit connects individually with those who come to church for help—speaking out encourages people suffering in silence to come forward, regardless of age.

Basic Assumptions

The following assumptions were considered when completing this research project. First, the research relies heavily on each participant supplying truthful and precise responses. Each participant's questions can make them shy or unwilling to be genuine; the researcher must ensure that they are safe (not an assumption). Secondly, each participant has a sincere interest in participating in the research and has no alternative motives, such as getting paid or impressing their pastor because they agreed to be in the study. Each participant willingly participates because they want to see the church change for the better. Another assumption is that many eager teenagers would be willing to volunteer to take the mental health survey. The leaders in ASIM are always supportive of new ideas and ways to improve the ministry. Therefore, it can be assumed that their response to the mental health training would be positive. Once the awareness

of mental illness is emphasized, the leaders will be more willing to break the stigma by continually speaking about it and looking out for it in the members.

Definitions

The following terms will be used throughout the project. These terms will be used in the manner prescribed by the precedent literature noted in each term's definition.

1. The words "*mental illness*" and "*mental disease*" will be used interchangeably- Mental illness/ disease refers to conditions that changes a person's thinking, feelings, or behavior (or all three), focusing on the health rather than the disease/ illness. It causes the person distress and difficulty in functioning.[12]
2. *Mental Health*- a state of well-being in which the individual realizes his or her abilities, can cope with the everyday stresses of life, can work productively and fruitfully, and can contribute to his or her community.[13]
3. *Public stigma*- the harmful effects of a label on an individual or a group, such as a racial, religious minority, or those diagnosed as mentally ill, occurs when the general population supports prejudice and subsequently discriminates against people with mental illness. Stigma is also the social devaluation of a person due to a profoundly discrediting attribute.[14]

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[12] Manderscheid, R. W., Ryff, C. D., Freeman, E. J., McKnight-Eily, L. R., Dhingra, S., & Strine, T. W. (2010). Evolving definitions of mental illness and wellness. *Preventing chronic disease, 7*(1), A19.

[13] Galderisi, S., Heinz, A., Kastrup, M., Beezhold, J., & Sartorius, N. (2015). Toward a new definition of mental health. World psychiatry : official journal of the World Psychiatric Association (WPA), 14(2), 231

[14] L Picco. E Abdin. S Pang. J A Vaingankar. A Jeyagurunathan. S A Chong. M Subramaniam. "Association between recognition and help-seeking preferences and stigma towards people with mental illness." National Library of Medicine, 27, no.1 (2018) 1.

4. *Mental health first aid*- MHFA is an evidence-based intervention to improve mental illness knowledge and self-efficacy in providing support; it will reduce mental illness stigma among church individuals and leaders.[15]
5. *Mental health literacy*- refers to knowledge and beliefs about mental disorders, which aid their recognition, management, or prevention.[16]
6. *Depression*- Depression is more than simply being sad; to be diagnosed with depression, a person must have five or more characteristic symptoms nearly every day for two weeks.[17]
7. *Anxiety*- An abnormal sense of fear, nervousness, and apprehension about something that might happen in the future.[18]
8. *Illness*- A problem in which some parts or parts of the body do not function normally, in a way that interferes with a person's life. For this study, other terms considered synonyms for illness include disease, disorder, and condition.[19]
9. *Psychiatrist* - A medical doctor (M.D.) who specializes in treating mental diseases. A psychiatrist evaluates a person's mental health and physical health and can prescribe medications.[20]

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[15] L Picco. et al., 2.

[16] Ibid., 1.

[17] National Institutes of Health (US), Biological Sciences Curriculum Study. "Information about Mental Illness and the Brain." NIH Curriculum Supplement Series, (2007).

[18] Ibid.

[19] National Institutes of Health (US), Biological Sciences Curriculum Study. "Information about Mental Illness and the Brain." NIH Curriculum Supplement Series, (2007).

[20] Ibid.

10. *Psychologist*- A mental health professional who has received specialized training in the study of the mind and emotions. A psychologist usually has an advanced degree such as a Ph.D.[21]

Limitations

Several factors can limit the scope of this project. First, the teenagers are underage and need supervision from parents to participate in the research. The parents can say yes or no, regardless of if the teenager wants to be involved. Secondly, for various reasons, none of the teenagers are diagnosed with mental illness. Therefore, there are possibilities that teenagers are not struggling with identified mental illnesses. A limitation could be that some participants drop off while the research is ongoing, which prevents the researcher from having enough participants for the study. Other restrictions could be that the church is unwilling to accept the training because they do not see its significance.

Delimitations

The first delimitation is that the research will be conducted in the church; therefore, the church will be informed of the results, which can be helpful. Selecting a specific number of teenagers and young adults can be controlled. Narrowing the research to specifically teenagers who understand mental illness and are currently battling it in their day-to-day life. The detailed demographic needed for the study can be controlled. The location in which the research will occur can be controlled. The initial stage of starting leadership training for mental illness and arranging this leadership team's curriculum can be controlled. The researcher will create the initial curriculum for the training that will fit and benefit the church. After the training, the church can then incorporate more lessons and topics into the curriculum.

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[21] National Institutes of Health (US), Biological Sciences Curriculum Study. "Information about Mental Illness and the Brain." NIH Curriculum Supplement Series, (2007).

Thesis Statement

The best time for individuals to learn how to control their emotions is when they are growing teenagers. One of the best environments to learn how to deal with these emotions is the church. In a church counseling program, the teenager would be equipped with tools and tactics to identify stressors. The counseling center would be an oasis that draws everyone closer to Christ. Teens need adult guidance more than ever to comprehend all the emotional and physical changes they continuously experience. If Arise and Shine International Ministries create a counseling center in the ministry, the teenagers may accurately convey their emotions and receive emotional healing. One of the ways to accomplish this is by learning about prevention and intervention in training. When the leaders recognize the signs of distress early on, the condition can be treated and managed earlier.

CHAPTER 2: CONCEPTIONAL FRAMEWORK

Literature Review

Up to 1 in 5 adults will develop a mental health illness at some point in life, and because of this high occurrence, members of the public are likely to have contact with someone who has a mental health problem.[22] This paper aims to research the similarities and differences of research provided regarding mental illness. The targeted audience is ministers and faith-based leaders with little to no mental illness experience.[23] This paper discusses mental illness, the stigmas behind mental illness, and mental illness training programs that churches desperately need.

Each year millions of people globally face the reality of struggling with a diagnosed or undiagnosed mental illness. Millions of people also battle these issues silently due to stigma, prejudice, and discrimination against mental illness people. Mental disorders are the fourth leading cause of disability in people aged 15-44.[24] Fear about lack of confidentiality is a significant reason for teenagers' disinclination to obtain support.[25] At this point, churches, clergies, faith leaders trained with adequate mental health knowledge can step in and provide the support teenagers urgently need.

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[22] Morgan, J. Amy, Ross, Anna, Nicola, J. Reavley. "Systematic review and meta-analysis of Mental Health First Aid training: Effects on knowledge, stigma, and helping behaviour." Plos one 18, no. 5 (2018) 3.

[23] Morgan, J. Amy, Ross, Anna, Nicola, J. Reavley. "Systematic review and meta-analysis of Mental Health First Aid training: Effects on knowledge, stigma, and helping behaviour." Plos one 18, no. 5 (2018) 2.

[24] Deborah Oyine Aluh, et al. "Cross-sectional survey of mental health literacy among undergraduate students of the University of Nigeria." National Library of Medicine, 9, no. 9 (2018) 1.

[25] Tylee A, et al. Youth-friendly primary-care services: how are we doing and what more needs to be done? The Lancet (2007) 1566.

Mental Illness

Mental illness is a global problem. More than 300 million people, 4.4% of the world's population, suffer from depression. More than a quarter of the world's population is between ages 10 and 24 years; at some point in this age, most major mental disorders occur. 1 in 5 young people (age 13-18) has or will develop a mental illness at some point in their lifetime.[26] Children and young people have clinically diagnosable mental problems. Also, worldwide, mental illnesses are the leading cause of disability in young people. At least 25% of young people are diagnosed with a mental or substance use disorder annually. Youth depression rates have equally risen from 5.9% to 8.2% since 2012. Depression symptoms can affect their performance in school and disturb their relationships.[27] These disturbing statistics indicate and prove the importance of mental health awareness. Unfortunately, young people's health has been virtually overlooked in global public health because this age group is perceived as healthy.[28] Mental disorder is not purely a lack of good mental health; it also includes psychological distress. Most people are affected when they experience difficult situations in life, such as various life situations, events, and problems.[29]

It is estimated that mental health conditions will affect at least one in five people at some point in their lives.[30] In a study titled *Evaluation of Mental Health First Aid training with*

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[26] "Mental Health Facts: Children and Teens." National Alliance on Mental Illness, 2017.

[27] Michaela C Pascoe, et al. "Exercise interventions for mental disorders in young people: a scoping review." B.M.J. Open Sport & Exercise Medicine, (2019) 1.

[28] Fiona M Gore, et al. "Global burden of disease in young people aged 10-24 years: a systematic analysis." National Library of Medicine, 18, no. 377 (2011) 2093.

[29] Jenkins, R., Baingana, F., Ahmad, R., McDaid, D., & Atun, R. (2011). Mental health and the global agenda: core conceptual issues. Mental health in family medicine, 8(2), 69–82.

[30] Pascoe, "Exercise interventions for mental disorders in young people: a scoping review," 1.

members of the Vietnamese community in Melbourne, Australia, the author states that "the importance of effective response to mental illness has become increasingly acknowledged as a result of epidemiological data showing the high prevalence of mental disorders in many countries, including Australia."[31] Another author states that yes, the occurrence of mental illness is high. Still, one must respond and "effectively treat youth mental disorders in a timely manner, which can reduce symptomatology, relapse and the potential persistence of illness."[32] Many people who get help early on either recover entirely or live with and manage their illness better.

The unfortunate reality is that 35% of the people battling this illness will never seek help from a trained mental health professional, such as a qualified therapist or psychologist. Instead, they are likely to seek counsel from family, friends, and church communities.[33] Though there is nothing wrong with seeking help and counsel from the church, if the church is unaware of this illness, they are likely to do more harm than good. This present generation of teenagers faces more complicated health and development matters than past generations. Mental disorder is one of the leading disease burdens teenagers face daily.[34]

Studies show that the enormous changes in their emotional and cognitive behaviors during adolescence, combined with puberty, have specific effects inimitable to this age group.[35]

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[31] Harry, Minas, et al. "Evaluation of Mental Health First Aid training with members of the Vietnamese community in Melbourne, Australia." International Journal of Mental Health Systems, 3, no. 19 (2009) 2.

[32] Pascoe, "Exercise interventions for mental disorders in young people: a scoping review," 1.

[33] Jennifer, Costello, et al. "Using mental health first aid to promote mental health in churches." Journal of Spirituality in Mental Health, 10 (2020) 1.

[34] Erskine, H. E., Moffitt, T. E., Copeland, W. E., Costello, E. J., Ferrari, A. J., Patton, G., Degenhardt, L., Vos, T., Whiteford, H. A., & Scott, J. G. (2015). A heavy burden on young minds: the global burden of mental and substance use disorders in children and youth. Psychological medicine, 45(7), 1551–1563.

[35] Haller, "Youth-friendly primary-care services," (2007) 1565.

Due to this, many young people are often reluctant to acquire needed health services. A study titled *Youth-friendly primary-care services: how are we doing and what more needs to be done?*[36] explains how young people are less enthusiastic about requesting professional help for more personal problems. Instead, they feel comfortable relying on trusted friends or family members. In some countries, the adults would even decide whether health care is needed or not, and if it were needed, the adult would pick the location. The research also underlines the fact that significant health problems for young people are mainly preventable. Young people need services and programs that are uniquely designed for their mental health. Access to primary health services is seen as an essential component of care, including preventive health for young people, but there is a barrier in receiving health services. With this enormous gap between the help young people seek and the disease burdens they endure, much work needs to be done to assist the teenagers.[37]

Stigma and Mental Illness

Stigma, prejudice, and discrimination against people with mental illness are extensive predicaments, leading to more harm and pain. The threat of stigma, and the effort to avoid the label, are so potent that more than half of the people with mental illness would benefit from psychiatric services but never obtain an initial interview with a professional. Stigma hurts, and it is taken personally by the victim.[38] Stigma is a global problem. There is no society, no country, no state, no family, where the stigma of mental illness is not present and potent.[39] Stigma or discrimination against people with mental illness, no matter how subtle, negatively impacts. One

[36] Ibid.
[37] Haller, "Youth-friendly primary-care services," (2007) 1566.

[38] Corrigan, "Challenging the Stigma of Mental Illness," (2011) 19.

[39] Ibid., xix.

of Challenging the Stigma of Mental Illness authors, Patrick Corrigan battled mental illness for over 25 years; he had significant depression and anxiety. One of the most common mental health disorders is depression, and he suffered silently. Corrigan consistently felt ashamed of this disorder and thought his family was embarrassed by him. He was always in and out of the hospital and refused to identify his mental illness publicly due to stigma; he felt that society would label him nuts.[40]

Stigma is formed out of the misconception society has regarding mental disorders. People who cope with their mental illness well enough to work have difficulties finding a job due to stigma. Nevertheless, most people with mental health issues can be as hardworking as people without mental health disorders, which leads to additional obstacles they would have to pass through personally. Some people may accept the prejudices, while others turn them against themselves and slowly lose self-confidence.[41]

Hayward and Bright define stigma as "the negative effects of a label placed on any group."[42] The authors of *Challenging the Stigma of Mental Illness* agree with this definition. They stress that to defeat the negative label placed on people, society needs to comprehend its capacity and understand the various forms.[43] In other words, society needs to have mental illness training. People with mental illness are disregarded daily due to ignorance; the more society is enlightened; the more stigma would be eliminated. Lack of knowledge about mental disorders

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[40] Corrigan, "Challenging the Stigma of Mental Illness," (2011) 20.

[41] Nicolas Rüsch, et al., "Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma." National Library of Medicine, 20, no. 8 (2005) 529.

[42] Aluh, "Cross-sectional survey of mental health literacy among undergraduate students of the University of Nigeria," (2018) 1.

[43] Corrigan, "Challenging the Stigma of Mental Illness," (2011) 23.

adds to the stigma; it prevents appropriate and timely help when efficient training comes in.[44] The misunderstandings of society about the various mental illnesses result in stigma. The negative effect of stigma is the need to create awareness and acceptance of affected persons more urgently. Stigma and discrimination have been recognized as the number one hindrance to assisting individuals with mental illness and their families.[45]

Religion and mental illness

Many people have discovered that religion, spirituality has a positive impact on their physical and mental health. Believing in something greater than oneself can help some persons live at peace with mental health conditions. In times of crisis, families hold onto faith as support through the recovery process. Others find that spiritual practices help them continue to manage their mental health. A substantial body of research reveals that religion is a strength and resilience source for many people who struggle with mental health disorders.[46] According to Deborah Cornah, religion, medicine, and healthcare have been entwined in one way or another since the beginning of recorded history. Not all research exploring the relationship between religious activity and mental health shows a beneficial effect. However, it depends to some extent on how spirituality is expressed. Strict religious upbringings and or rules can lead to increased mental health problems. People also find that their religious or spiritual beliefs are not understood or explored within mental health services.[47]

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[44] Minas, "Evaluation of Mental Health First Aid training with members of the Vietnamese community in Melbourne, Australia," (2009) 2.

[45] Adeola O. Oduguwa, et al., "Effect of a mental health training programme on Nigerian school pupils' perceptions of mental illness." Child and Adolescent Psychiatry and Mental Health, 11, no. 19 (2017) 2.

[46] Pargament, Kenneth I. Lomax, James W. "Understanding and addressing religion among people with mental illness." National Library of Medicine, 12, no.1 (2013) 26.

[47] Deborah Cornah. "The impact of spirituality on mental health," 2006.

Another source mentions that ministries, churches, temples, mosques, and synagogues are potential support for individuals with various mental disorders.[48] Faith and religion are a vital part of mental health treatment and recovery.[49] Ignorance is not an excuse for believers any longer. As disciples of Christ, believers need to "bear one another's burdens," according to Galatians 6:2 (New King James Version). Though considerable improvements have been made regarding bringing the Christian and mental health communities together, more work is needed.[50] When a traumatic crisis occurs, faith leaders are usually the first contact point. Many individuals and families turn to reliable leaders in their communities before going to any health professional. As a result, faith leaders and ministries need to understand mental illness; once they do, they become significant assets to the individual. Due to their previous impact on people's lives, religious leaders may be better suited for motivating people. Faith-based families frequently turn to the church for moral guidance.[51]

There are so many articles, research studies, and books to support this stance. The research titled, *Demon or disorder* concludes that people battling any psychological distress are more likely to get help from religious leaders than any other professional. The researchers believe that spiritual assistance offers people resources typically not offered during professional secessions. Religious service such as prayer, reading the Scriptures, hymns, and singing plays an

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[48] James L. Griffith. et al., "How Can Community Religious Groups Aid Recovery for Individuals with Psychotic Illnesses?" National Library of Medicine, 52, no. 7 (2016) 780.

[49] Ibid., 6.

[50] Stanford, Matthew S. "Demon or disorder: A survey of attitudes toward mental illness in the Christian church." Mental Health, Religion and Culture, 10, no. 5 (2007) 449.

[51] Corrigan, "Challenging the Stigma of Mental Illness," (2011) 119.

essential role in recovery.[52] A second article affirms that well-structured religious aid can play a significant role in recovering the individual and preventing mental illness. It mentions that innovative training programs are needed to enable recovery and provide emotional support and understanding these young people need.[53] A third article shows that religion and spirituality can be helpful to individuals. Faith leaders can provide a support system and coping strategies during their recovers.[54]

In Nigeria, religion, spirituality, churches, mosques, and other places of worship are essential in the Nigerian people's lives. Nigerians hold their belief with high reverence. As a result, many Nigerians feel more comfortable relating to their faith leader about emotional and mental health issues. Nigerians take their religion very seriously; their faith leaders are esteemed and seen as leaders sent from God. About 61% of adults in Nigeria requested counseling from their church before seeing a mental health professional. Nigeria demonstrates the severe lack of capacity for mental healthcare facilities but an emphasis on religion. Furthermore, the stigma and negative attitudes toward people with mental illness are common even within religious groups. Creating a merger between the mental health facilities and the church will benefit individuals and the community.[55]

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[52] Stanford, "Demon or disorder," (2007) 445.

[53] Stanford, 448.

[54] Rogers, Edward B. Stanford. Matthew S. "A church-based peer-led group intervention for mental illness." Mental Health, Religion & Culture, 18, no. 6 (2015) 470.

[55] Iheanacho, Theddeus. Stefanovics, Elina. Ezeanolue, Echezona E. "Clergy's Beliefs About Mental Illness and Their Perception of Its Treatability: Experience from a Church-Based Prevention of Mother-to-Child H.I.V. Transmission (PMTCT) Trial in Nigeria." J Relig Health, 57 (2018) 1484.

Formal Training

An overwhelming amount of research points to the need for formal mental health training for churches and faith leaders. The minimum church assistance is not an alternative for mental health care. The church is an oasis for those in need. Therefore, the church must be adequately trained to minister to the people unable to access professional care outside their church.[56] Evidence indicating a substantial percentage of clergy lack formal training and feel unprepared to handle mental and emotional health problems among congregants is alarming.[57] This alone proves that much work is needed to be done in churches.

According to *Concepts, consequences, and initiatives to reduce stigma*, the three main approaches to fighting mental health stigma are protest, education, and contact.[58] Corrigan and Penn also pinpointed three tactics to reduce public stigma: demonstration, education, and contact.[59] Community-based mental health training is necessary to equip and prepare faith leaders in churches. This training will appropriately respond to individuals and families experiencing mental health crises.[60] Formal educational training can reduce stigma by providing accurate information regarding mental health. Different forms like books, videos, and structured teaching programs have been used to communicate this knowledge. Brief educational courses on mental illness for churches and individuals are proven to decrease the stigmatizing mindsets.[61]

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[56] Rogers, "A church-based peer-led group intervention for mental illness," (2015) 470.

[57] Morgan, J. Amy, Ross, Anna, Nicola, J. Reavley. "Systematic review and meta-analysis of Mental Health First Aid training: Effects on knowledge, stigma, and helping behaviour." Plos one 18, no. 5 (2018) 2.

[58] Rüsch, "Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma," (2005) 535.

[59] Corrigan, "How Stigma Interferes with Mental Health Care," (2004) 620.

[60] Costello, "Using mental health first aid to promote mental health in churches," (2020) 2.

[61] Rüsch, "Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma," (2005) 535.

Another article states that educating faith leaders is an excellent way to eliminate stigma and change society's mental illness attitude. The researchers believe that the faith leaders will develop training for their congregation, which changes their mindset regarding the topic.[62]

Mental Health Training Programs

A well-known training is the Mental Health First Aid (MHFA) training program. This program was established to expect individuals with mental health problems to receive needed assistance from those already comfortable. The program will train and equip volunteers, such as faith leaders, to improve resources available to people in need.[63] In addition, MHFA was established to bring understanding to the cracks in mental health knowledge. There are many myths regarding mental health; teaching skills to identify and help individuals experiencing emotional distress raises awareness. Also, MHFA teaches necessary information about mental health problems, offers detailed information on local mental health resources, and raises awareness about stigma.[64]

MHFA is gaining ground in various communities and countries around the world. MHFA plays a substantial role; it provides mental health support in communities that lack health care professionals. A certified MHFA instructor teaches MHFA courses; the instructor is usually a state and local mental health authority or organizations focused on behavioral health, mental health, or addictions.[65] The training's format is generally through a single 8-hr session or over

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[62] Corrigan, "How Stigma Interferes with Mental Health Care," (2004) 119.

[63] Minas, "Evaluation of Mental Health First Aid training with members of the Vietnamese community in Melbourne, Australia," (2009) 2.

[64] Tramaine El-Amin, et al. "Enhancing Mental Health Literacy in Rural America: Growth of Mental Health First Aid Program in Rural Communities in the United States From 2008–2016." Journal of Rural Mental Health, 42, no.1 (2018) 21.

[65] Ibid., 29.

two days in 4-hr sessions. The program teaches mnemonic action steps for the MHFA training that is easily remembered. ALGEE, which stands for A- assessing the situation. L- Listening without judging the individual, G- Giving reassurance and helpful information. E- Encouraging the patient to seek professional assistance, and E- Encouraging self-care tactics. The training also teaches essential details about mental health issues and offers detailed information on resources available. The program also creates awareness about stigma in society and ways to educate others.[66] Another training program was researched in Nigeria; this was an intervention for those battling mental health. The training was a mental health awareness training provided by Ado-Odo Ota (A.O.O.). The training was 5 hours over three days: 2 hours each on the first two days and 1 hour on the third day. The training is based on a manual titled *Training materials for multipurpose care workers in developing countries,* and the *Teachers' knowledge, attitude & practice questionnaire*.[67]

Both manuals had cases that described the possible presentations, causes, and treatment of a mental illness tailored to fit their training. This study used multiple teaching formats, such as educational lectures, group discussions, and role-plays to guarantee student involvement and learning. [68] Many of the volunteers liked the training because it expanded their knowledge about mental illness. The training changed their belief about mental illness and helped them develop compassion for people rather than judge. Mental health training should motivate participants to

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[66] Tramaine El-Amin, et al. "Enhancing Mental Health Literacy in Rural America: Growth of Mental Health First Aid Program in Rural Communities in the United States From 2008–2016." Journal of Rural Mental Health, 42, no.1 (2018) 29.

[67] Adeola O. Oduguwa, Babatunde, Adedokun. Olayinka O. Omigbodun. "Effect of a mental health training programme on Nigerian school pupils' perceptions of mental illness." Child and Adolescent Psychiatry and Mental Health, 11, no. 19 (2017) 4.

[68] Ibid., 4.

seek ways to help those battling the disease.[69] Innovative training programs are needed to facilitate healing in the religious setting and provide emotional support and understanding.[70] The negative connotation between religion and psychology has drastically changed over the years. Researchers have seen the importance and positive outcomes both can have on each other if appropriately explored. Religion is now viewed as an essential source, and psychologists no longer underestimate religion's importance to patients.[71]

Conclusion

There is a growing body of research concerning the need for churches to be trained regarding mental health. Unfortunately, there are still many wrong ideologies regarding the cause of mental health. Some churches still strongly believe supernatural evil forces strictly cause mental illness.[72] Mental health training programs with multiple training secessions geared towards churches can significantly change mental illness knowledge. Mental health professionals need to collaborate with churches, clergies, faith-based leaders to create a mental health training curriculum for churches. Which would incorporate various secession focused on equipping volunteers to see the signs and help those in need.

As reflected in the literature review, mental illness is a global predicament, and more churches should be trained and equipped to assist them. This review has discovered a gap that could be further investigated. Mental illness training has yielded positive outcomes in various churches. However, there is limited research regarding the Mental health first aid (MHFA)

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[69] Ibid., 6.

[70] Rogers, "A church-based peer-led group intervention for mental illness," (2015) 471.

[71] Pargament, "Understanding and addressing religion among people with mental illness," (2013) 27.

[72] Iheanacho, "Attitudes and beliefs about mental illness among church-based lay health workers" (2015) 8.

training effects on undiagnosed Nigerian teenagers. These studies focus on individuals diagnosed with mental illness; hence, the undiagnosed individuals' effects are unclear. Given the increasing levels of mental illness among Nigerians and the significant stigma, the present study is needed to investigate training effectiveness such as MHFA in Nigerian churches.

Theological Foundations

There are biblical principles that serve as the underlying or foundation of this thesis. Every faith leader must understand the difference between spiritual struggle, weakness, and mental illness. At times, the difficulty a person experiences causes people to assume sin is the problem. In some cases, it is simply a spiritual struggle, and in some, it is a weakness that leads to guilt, depression, anxiety, and eventually mental illness. In Hebrews 4:15, the Scripture explains that Jesus, the High Priest, understands the believer's weaknesses and sympathizes with them. A trained faith leader should be equipped to help people deal with sin in their lives, grow through their spiritual struggles, comfort, and encourage them through their weaknesses and address mental illnesses.[73] There are various biblical examples of individuals who struggled with mental illness as they did the work of God. Mental illness did not begin in the 21st century; people like David, Jeremiah, Paul, and Judas went through depression, anxiety, suicide, and emotional disorder.

David

Mental illness is a condition that affects a person's thinking, feeling, mood, and behavior; the pain of this disorder is real. People suffer in silence and feel abandoned by God, blaming the illness on a spiritual failing when grace abounds. David, a man after God's heart, went through a

[73] Ed Stetzer, Jared Pingleton, Donald Graber. *Serving those with Mental Illness* (2014), 4. https://media.focusonthefamily.com/pastoral/pdf/PAS_eBook_Series_Mental_Health_INTERACTIVE.pdf.

series of depressive cycles; he also suffered in silence but always gave himself to prayer. It is common to stop prayer during the lowest point of life, but David, afflicted in spirit, continued to pray. In the commentary *Exalting Jesus in Psalms 51-100*, David Platt states, "it is possible to be greatly shaken and yet still trust in God."[74] In Psalm 69:1-3 (NJKV), David writes, "Save me, O God! For the waters have come up to my neck. I sink in deep mire, where there is no standing; I have come into deep waters, where the floods overflow me. I am weary with my crying; my throat is dry; my eyes fail while I wait for my God." In these verses, David complains of his troubles and battles, intermingling with those complaints some requests for relief from God. Upon all his weary tears to God, he receives no help or answer from God.[75] The silence from God is enough to torture a person mentally, especially when the person is in desperate need. David had many times where prayer was necessary; he built his strength regularly from his constant prayers to God.

In *Matthew Henry's Commentary on The Whole Bible*, Matthew Henry explains in Psalm 69 that David pours out his complaints before the Lord with the hope of some ease from God. He complains of the deep impressions that his troubles made upon his spirit. At this point, David had no hope, and his soul was wounded; he had no foundation; he was overwhelmed, sinking in despair, confused, and filled with agony.[76] According to *Enduring Word Commentary*, people feel like things rush in on them many times, like drowning in a flood. Other times it's as if the water level slowly rises until they are overwhelmed; each has its own type of fear and misery.

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[74] Platt, D., Mason, M., & Shaddix, J. *Exalting Jesus in psalms 51-100*. Nashville: B&H Publishing Group (2020) 276.

[75] Ibid.

[76] Matthew Henry, Matthew Henry's Commentary on the Whole Bible, (Peabody, MA: Hendrickson Publishers, 2008).

The fear and water rising are precisely what David passed through alone. Verse 4 begins by describing the real problems David expressively portrayed in the previous verses. His thoughts needed something or someone to confide in, reassure him and give him hope, but he found none. David was ready to give up; he was mentally and emotionally exhausted, struggling with inward agony. David was sinking in confusion and dismay, similar to what Christ suffered. David lived under the tremendous stress of knowing many people hated him without cause. He was treated as though he was guilty, while he was innocent.[77]

Jeremiah

Jeremiah, a prophet who lived 400 years after David, went through similar challenges in obedience to God. Jeremiah told people exactly what God told him to say, and the people did not like it. Jeremiah was hurt in many ways and jailed for no reason. The Scriptures are unambiguous that David and Jeremiah were called and set apart by God before He formed them in the womb. God clearly said, "I ordained you a prophet to the nations." Accepting the call does not stop trials or mental illness, as seen in Jeremiah's life. Jeremiah 38:6, "So they took Jeremiah and cast him into the dungeon of Malchiah…they let Jeremiah down with ropes. And in the dungeon, there was no water but mire. So, Jeremiah sank in the mire."

According to *Enduring Word Commentary*, God's message through Jeremiah did not change while in the dungeon. Those that put him in there expected him to die of cold and hunger. In this distress, Jeremiah wrote Lamentations 3:55 and 57 out of a low point in his life. Jeremiah went through so much mental anguish that, at the moment, he refused to "make mention of Him, nor speak any more in His name." (Jeremiah 20:9)[78] In *Dake's Annotated Reference Bible*, F.

[77] David Guzik, The Enduring Word Bible Commentary. https://enduringword.com/bible-commentary/psalm-69.

Jennings Dake highlighted that Jeremiah felt deceived. He had no idea how much mockery and defeat he would pass through when he answered the call. Jeremiah believed he was a failure, and his labor was in vain. He refused to mention the Lord's name because all he was receiving was dishonor and disgrace.[79]

A prophet sent from God, Urijah, prophesied out of the flesh and was killed instantly, while God had mercy upon Jeremiah's life. With an aching heart filled with anguish, Jeremiah wrote Lamentations 3:22 "through the Lord's mercies we are not consumed, because His compassions fail not." According to *Matthew Henry's Commentary of the Whole Bible*, Jeremiah was in and out of depression; he had several near-death experiences. Jeremiah was at such an unstable point in his life that he possibly contemplated suicide. In 20:13, he sang praises to God; then, in 20:14, he was back into hopelessness, beginning to curse the day he was born. Jeremiah went through intense trials and challenges; he was mocked, beat, and whipped. He prophesied God's message with his whole heart, but the people refused to listen to him. They abandoned the true fountain and followed a broken system.[80] These are daily battles believers go through today; as God was with David and Jeremiah even in their darkest hour, God is with His children struggling mentally today.

Peter

These examples are not limited to the Old Testament; Peter went through depression after betraying Jesus in the New Testament. Jesus warned him, told him what was going to happen, and he still sinned against God. Luke 22:62 (AMP), "and he went out and wept bitterly, deeply

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[78] David Guzik, The Enduring Word Bible Commentary. https://enduringword.com/bible-commentary/jeremiah-38.

[79] Finis Jennings Dake, Dake's Annotated Reference Bible, (Lawrenceville, GA: Dake Bible Sales, Inc, 1993).

[80] Matthew Henry, Matthew Henry's Commentary on the Whole Bible, Jeremiah 20:13-14

grieved and distressed." The guilt Peter felt at that moment is enough to pull him away from Christ. According to Dake, this brought him to his senses and towards repentance. Peter was ashamed of his master at the point of denial, the sight of seeing Christ bound and at the mercy of the rulers made his faith stagger. Christ prayed that Peter's faith should not fail or be overwhelmed, implying that the attack was made on his faith and wavered and recovered steadfastly.[81] *Enduring Word Commentary* explains that Peter was instantly convicted of his sin, not only of his denial of Jesus but also of the pride that led him to think he could never deny Him. Peter remembered the words of Jesus after he sinned; all he could do was sob bitterly. His tears symbolized his shame, remorse, anxiety, and sorrow. Peter knew he let the Lord down because he broke his Word; he felt untrustworthy to the Lord. In a few hours, Jesus was betrayed by Judas and then denied by Peter. To a certain extent, Peter was weeping because he realized he was no better than Judas.[82]

Judas

Guzik also described that Christ looked at Peter out of love, which moved him to repentance. Though Peter betrayed his master, he was not without hope; he fell but did not fall away like Judas.[83] Judas and Peter had similar hearts, imperfect human hearts like every believer. The same doubts that tormented Peter were the same doubts that haunted Judas and prevented him from coming back to Jesus for mercy. *Matthew Henry's Commentary on The Whole Bible* states that both Judas and Peter betrayed Jesus, as do many believers today; their response after the betrayal was different. Jesus never left their side, although they both left His. No matter how

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[81] Finis Jennings Dake, Dake's Annotated Reference Bible, Luke 22:62.

[82]David Guzik, The Enduring Word Bible Commentary. Enduring https://enduringword.com/bible-commentary/luke-22.

[83] Ibid.

damaging, hurtful, horrible, separating a sin is, the grace to return to God and mend the brokenness in the mind prevails. Paul wrote, "but where sin abounded, grace abounded much more" (Romans 5:20). Unquestionably, grace was all the more available to both Judas and Peter in the bleakest moments of their sin. The grace, mercy, and love of God were present to both of them after they betrayed Jesus. Judas chose to stay away and commit suicide; he decided to remain separated from the love of God. But Peter responded to grace and continued his walk with Christ. [84] Peter had a repentant heart which was contrary to Judas.

Even though Satan entered Judas, Judas permitted him to come in; if he resisted Satan, he would have left. Judas's mindset was wrong, and this was the battleground in which the devil used him to work. He was filled with greed, selfishness, and unworthy thoughts; his mind was not renewed like the other disciples.[85] This is why the Bible plainly states in Romans 12:1 to "present your bodies a living sacrifice, holy, acceptable to God." Even though God used Judas's actions to bring salvation to the world, Judas did not experience salvation. This proves the importance of repentance; Judas was not inwardly remorseful for his action.

Judas was not repentant enough to want repentance from God; he refused to let go of his pride. Today, people struggle with their mental health secrets and refuse to seek help but instead take their own lives. Individuals unwilling to seek proper counseling can open the door for Satan to steal, kill and destroy them according to John 10:10, just as he did for Judas. In The Oxford Bible commentary, John Barton also states that Judas was selfish and sought his gain. In complete contrast to everything Jesus has taught, Judas was greedy for money. Brian Bell Commentary on the Bible explains that Judas brought despair and betrayal, but because of that,

[84] Matthew Henry, Matthew Henry's Commentary on the Whole Bible, Romans 5:20.

[85]John Muddiman and John Barton, The Oxford Bible Commentary (Oxford: OUP Oxford, 2007).

the world today has the hope, love, peace, and eternity promised by the Lord Jesus. Judas' kiss showed just how low a human heart could go, but Jesus' response showed how high a heart could soar amid betrayal.[86] Judas was no sinner above all others. He was a very human character, and he was tempted, as we all are at the point of his greatest strength. Like so many today, Judas trusted the voices in his mind rather than the voice of truth, Jesus Christ. Faith leaders need more guidance and training for dealing with mental health crises, especially those struggling with mental illness caused by known sins. Churches need to have a set plan to help families affected by mental illness and ongoing spiritual care for the individuals. Mental illness is not easy to discuss, but churches need spiritually, physically, and mentally healthy members.

Theoretical Foundations

This topic has been researched in various ways and from multiple angles. There have been scholarly sources on mental illness in the church. It is now known that mental disease results from something that happens to an individual. As with many conditions, mental illness is severe in some instances and mild in others. Individuals who have a mental illness don't necessarily look sick, mainly if their illness is mild. Each illness changes a person's thoughts, feelings, and behaviors in distinct ways.[87] The person was healthy, then something happened, and the person responded by becoming ill; it was not a choice. The Bible teaches a strong position on individual responsibility to various illnesses. Shifting the blame to genes, parents, horrible experiences, bad social environment, or peers' lousy influence is not an excuse. It is essential to understand that mental illness is not a choice, but the preferences made during the

[86] Bell, Brian. "Commentary on Mark 14:43". "Brian Bell Commentary". https://www.studylight.org/commentaries/cbb/mark-14.html. 2017.

[87] National Institutes of Health (US), Biological Sciences Curriculum Study. "Information about Mental Illness and the Brain." NIH Curriculum Supplement Series, (2007).

illness are a personal decision. Nowhere in Scripture does any sickness excuse believers from their transgressions.[88] Churches must have a training program to guide and navigate believers struggling with illnesses today. Given the importance of churches, promoting mental health training within the church has received growing attention from researchers and clinicians to execute community-based health programs.[89]

A theory about implementing a mental health ministry committee in Faith-Based Organizations proved that it could raise awareness and promote depression treatment-seeking, specifically among African Americans. The African American churches have the highest documented church attendance percentages among all ethnic groups in the United States; it can effectively reach vast neighborhoods and possibly distinctively facilitate mental health awareness in the communities. The researcher believes that faith-based leaders have a valuable role in mental health service delivery and should take hold of it. The leaders are trusted gatekeepers in the African American communities, so they should have sufficient training to manage depression, substance use disorders, domestic violence, psychotic disorders, etc. Faith-based leaders need to be educated in the Word and the signs and symptoms of depression and be conversant about their community's mental health resources. In this theory, the researchers created a *Faith-Based Health Promotion* program designed to provide significant benefits to community members through education, screening, and treatment.[90] They also started a health

[88] Thomas, Alan. Tackling mental illness together: A biblical and practical approach. (London: IVP, 2017) 63.

[89] Campbell et al., 2007

[90] Williams, L., Gorman, R., & Hankerson, S. Implementing a mental health ministry committee in faith-based organizations: the promoting emotional wellness and spirituality program. Social work in health care, 53(4), 2014, 414–434.

ministry, which is a committee of church leaders and community members serving within a church that provides health education and services to its congregants.

Another theory is that religious communities can be a bridge in mental illness service. Participating and serving in church is not a substitute for mental health care, yet many mental health needs never seek professional care outside their church. An increasing amount of evidence indicates that religious individuals want religion and spirituality integrated into mental health interventions and experience. The solution was to create a Living Grace Group. Living Grace Group is a peer-led, faith-based, psychoeducational support group for those living with any identified psychiatric disorder. This is not a therapy group; the main focus is on a recovery model which emphasizes encouraging participants, teaching practical tools, and providing support. Leaders of groups are identified from inside a faith community that sponsors the group. The leader must be someone who has recovered from a mental illness, has a loved one with a mental illness, or is involved in other mental health advocacy work. Each leader must be trained to lead the group. The group does not focus on any specific mental illness but addresses the common factors found in most mental disorder diagnoses.[91]

A final theory speaks about another culture that exhibits the same traits. Asian Americans are also less likely to discuss death and communicate their wishes for end-of-life care. In several ethnic groups, churches play a substantial role in health promotion. The solution was to conduct sessions facilitated by research staff with health education experience. In this study, there was a change in the faith-based churches after two educational programs promoting mental health.[92]

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[91] Edward B. Rogers & Matthew S. Stanford. A church-based peer-led group intervention for mental illness, Mental Health, Religion & Culture, 18:6, (2015) 470-481.

[92] Sun, A., Bui, Q., Tsoh, J.Y. et al. Efficacy of a Church-Based, Culturally Tailored Program to Promote Completion of Advance Directives Among Asian Americans. J Immigrant Minority Health 19, 381–391 (2017).

All these theories prove that training does create awareness and change within the church. It also proves that if the church recognizes and admits mental illness exists within the body of Christ, they will minister accordingly.

Though these theories have been explored and researched, one approach has not been thoroughly investigated. This theory is whether mental health training programs will benefit Nigerian teenagers in the church. Another idea that has not been looked further into is more communication with the community about mental illness in the church. Another theory that has not been explored yet is if a leadership team of ASIM will undergo intensive training and if it would be beneficial to the church. Mental health advocacy is so important that a positive outcome from this study would be for churches to create a healthy environment for everyone, including the pastor, to be transparent with such issues. The primary action step is to be practical. First, build a team of volunteers, including the pastors and leaders. Then either create or build on a curriculum about mental health that would fit the needs of ASIM. Then begin a recovery ministry where the community can be safe to seek help led by a pastor who has been through mental health training. Each person’s condition differs and must be carefully assessed and their treatment individually.

CHAPTER 3: METHODOLOGY

This chapter will describe the specific details regarding the implementation of this thesis project. The author outlines the research strategy, the research method, the research approach, the methods of data collection, the research process, the type of data analysis, the ethical considerations, and the research limitations of the project. A research methodology describes how the research will be overseen, how the data will be collected and analyzed, and how solutions will be provided to questions being investigated. The procedure should be carefully chosen based on addressing the research purpose, theories, and research questions.[93] Sensing explained that one of the natures of qualitative research is action. Action research solves a problem within a community using the people's lives experiences. It intends to solve specific problems within a system, or community and becomes part of the transformation by researching and questioning the people directly in the program.[94] The qualitative research was selected as the best method to fulfill the research's purpose and manage the various views and research questions.

The researcher gained qualitative data using anonymous surveys, an anonymous pre-test, and anonymous post-test surveys analyzed and synthesized by utilizing ATLIS. TI. The researcher chose an anonymous survey research design because it best served to answer the questions and the purposes of the study. This research aims to determine if any teenager in Arise and Shine International Ministries has had mental health struggles. Mental health includes the emotional, psychological, and social well-being of an individual. The anonymous survey will determine if a certain percentage of teenagers have been affected at some point in time. It also

[93] Leavy, P. (2017). Research design: Quantitative, qualitative, mixed methods, arts-based, and community-based participatory research approaches. The Guilford Press.

[94] Sensing, *Qualitative Research,* 56.

helps determine how the church assisted them during this time of need. The second part of the research is to educate the leaders of Arise and Shine International Ministries about mental health. Mental health is an essential component of an individual's overall health and well-being. The training could lead to the church realizing how common and treatable mental illness is. This realization could possibly lead to an effective change. The researcher will conduct a pre-test, a post-test during the 3-week training, and a debrief session to discuss the data.

This research aims to provide an awareness of mental health within Arise and Shine International Ministries and create support for those adolescents struggling with a range of mental health issues. To achieve this goal, the researcher will attempt to prove that a minimum of 15 teenagers within the church are struggling with various mental health issues ranging from depression, suicide, schizophrenia, etc. This research will be conducted by having the teenagers who voluntarily agree to participate in this study by completing an anonymous survey. The researcher observed several teenagers in the church struggling with various forms of mental illness. The researcher will establish a baseline for measuring change by encouraging teenagers in the church to be included and involved in the survey. The research methodology identifies and analyzes information about the topic, such as collecting and analyzing the data. According to Stringer, it is a systematic and meticulous investigation that empowers individuals to understand the nature of various events and experiences.[95] This methodology is focused on a particular problem or issue that can lead to development in the church community.

[95] Ernest T. Stringer, *Action Research*, Edition 4 (Los Angeles, CA: Sage Publications, Inc., 2014). 6.

Implementation of the Intervention Design

The intended project is based solely on the teenagers and leaders within Arise and Shine International Ministries in Bedford, Texas. An institution Review Board (IRB) application was completed and approved on July 23rd, 2021 before the actual study began. The researcher adhered to all IRB requirements during the research process. The obtained IRB approval letter (see Appendix A) and consent form from the church (See Appendix B) are attached. The implementation of the intervention will be executed in a two-step process. The two-step process will be implemented using the qualitative research method. The researcher must complete this study in an equitable state to allow the results to speak for themselves. According to Patricia Leavy, qualitative research allows the researcher to accomplish community change and action.[96] Using an anonymous survey for the first step allows the researcher to gain accurate insights into the participant's perceptions in the community.

First, the researcher will sit with the church's bishop to define the research, the purpose, and how it can potentially benefit the ministry. Once the consent form has been acquired and signed, the researcher will obtain the number of current leaders and the positions they fill from the church secretary. The names collected will only be used to count leaders accurately and ensure that every leader in a leadership position is accounted for. The researcher will then meet with the youth pastor to get an updated list of all the teenagers in the church. The researcher will contact the teenagers and parents personally using the verbal recruitment form. The parents and teenagers will be contacted by meeting with them face to face on Sunday mornings. If the parents or the teenagers cannot be reached on a specific Sunday, they will be reached via phone, text, or email.

[96] Leavy, Research Design, 6.

The parents of the potential pool of 15 to 20 adolescents will then be invited to attend a parent meeting to address the focus of this study, which will highlight the need for an adolescent mental health program within the local church. The parent information meeting will take place on a Sunday after the second service. The parents will have access to the survey questions their child may complete as a measure of informed consent to review their child's answers. The researcher will read and explain the parent/ child consent form. Presenting that though the researcher serves as a pastor at Arise and Shine International Ministries, the study will be anonymous to limit potential or perceived conflicts, so the researcher will not know the responses of those who participated. However, the parents will not see what answers their child provided to protect anonymity. This disclosure is made to decide if this relationship will affect their willingness to allow their child to participate in the study. No action will be taken against an individual based on their decision to remove their child from the study.

Participation is voluntary, and if a family chooses to withdraw from the study, the researcher must be informed. If the participant wishes to discontinue their involvement while taking the survey, the child should not submit the study materials. Their responses will not be recorded or included in the study at that point. The parents are encouraged to contact the researcher via email at bonaiwu@liberty.edu. They can also contact the researcher's faculty sponsor, Dr. Teresa Duez, at tduez@liberity.edu. Parents will be informed that they are also encouraged to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515, or email at irb@liberty.edu.

After the session, both the parent and child will sign the consent form agreeing to participate. Once informed consent is achieved by having both parent and their child sign the consent form, they will choose a convenient time for the survey. On the day of the study, the

researcher will print out the study and prepare the classroom used. The adolescent will then complete the anonymous survey using as much time as they need. This survey will take approximately 30 to 45 minutes to complete and be done in a private area of the church to protect confidentiality. The survey designed will ask the following questions, one open-ended response, and 19 multiple choice questions:

1. What does mental health mean to you?

2. How important is religion in your life?
    a. 1=Very Important
    b. 2=Important
    c. 3=Neutral
    d. 4=Unimportant
    e. 5=Very unimportant

3. How satisfied are you with your overall experience at church?
    a. 1=Very dissatisfied
    b. 2=Dissatisfied
    c. 3=Somewhat dissatisfied
    d. 4=Somewhat satisfied
    e. 5=Satisfied
    f. 6=Very satisfied

4. How satisfied are you with your mental stability?
    a. 1=Very dissatisfied
    b. 2=Dissatisfied
    c. 3=Somewhat dissatisfied
    d. 4=Somewhat satisfied
    e. 5=Satisfied
    f. 6=Very satisfied

5. How many days have you felt that emotional or mental difficulties have hurt your academic performance in the past four weeks?
    a. 1=Not at all
    b. 2=Several days
    c. 3=Over half the days
    d. 4=Nearly every day

6. I lead a purposeful and meaningful life
    a. 1=Strongly agree
    b. 2=Agree
    c. 3=Somewhat agree

   d. 4=Somewhat disagree
   e. 5=Disagree
   f. 6=Strongly disagree

7. I actively contribute to the happiness and well-being of others.
   a. 1=Strongly agree
   b. 2=Agree
   c. 3=Somewhat agree
   d. 4=Somewhat disagree
   e. 5=Disagree
   f. 6=Strongly disagree

8. Over the last 2 weeks, how often have you been bothered by depression, little interest or pleasure in doing things, feeling down, depressed or hopeless, feeling tired or having little energy, poor appetite or overeating,
   a. 1=Not at all
   b. 2=Several days
   c. 3=Over half the days
   d. 4=Nearly every day

9. Over the last two weeks, how often have you been bothered by feeling bad about yourself—or that you are a failure or have let yourself or your family down.
   a. 1=Not at all
   b. 2=Several days
   c. 3=Over half the days
   d. 4=Nearly every day

10. Over the last 2 weeks, how often have you been bothered by the following problems? Feeling nervous, anxious, or on edge, not being able to stop or control worrying, feeling afraid as if something awful might happen, becoming easily annoyed or irritable, worrying too much about different things, trouble relaxing, being so restless it is hard to sit still.
    a. 1=Not at all
    b. 2=Several days
    c. 3=Over half the days
    d. 4=Nearly every day

11. Over the last 2 weeks, have you had difficulty sleeping?
    a. 1=Yes
    b. 0=No

12. Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way

a. 1=Not at all
b. 2=Several days
c. 3=More than half the days
d. 4=Nearly every day

13. In the past year, did you ever seriously think about attempting suicide?
    a. 1=Yes
    b. 0=No

14. How much do you agree with the following statement? If I needed to seek professional help for my mental or emotional health, I would know where to go in the church.
    a. 1=Strongly agree
    b. 2=Agree
    c. 3=Somewhat agree
    d. 4=Somewhat disagree
    e. 5=Disagree
    f. 6=Strongly disagree

15. How helpful on average do you think therapy or counseling is when provided competently for people your age who are clinically depressed?
    a. 1=Very helpful
    b. 2=Helpful
    c. 3=Somewhat helpful
    d. 4=Not helpful

16. How much do you agree with the following statement? Most people think less of a person who has received mental health treatment.
    a. 1=Strongly agree
    b. 2=Agree
    c. 3=Somewhat agree
    d. 4=Somewhat disagree
    e. 5=Disagree
    f. 6=Strongly disagree

17. How much do you agree with the following statement? I would think less of a person who has received mental health treatment.
    a. 1=Strongly agree
    b. 2=Agree
    c. 3=Somewhat agree
    d. 4=Somewhat disagree
    e. 5=Disagree
    f. 6=Strongly disagree

18. How much do you agree with the following statement? In the past 12 months, I needed help for emotional or mental health problems such as feeling sad, blue, anxious, or nervous.
    a. 1=Strongly agree
    b. 2=Agree
    c. 3=Somewhat agree
    d. 4=Somewhat disagree
    e. 5=Disagree
    f. 6=Strongly disagree
19. Have you ever done any of the following intentionally in the past year? (Select all that apply)
    a. 1=Cut myself
    b. 2=Burned myself
    c. 3=Punched or banged myself
    d. 4=Scratched myself
    e. 5=Pulled my hair
    f. 6=Bit myself
    g. 7=Interfered with wound healing
    h. 8=Carved words or symbols into skin
    i. 9=Rubbed sharp objects into the skin
    j. 10=Punched or banged an object to hurt myself
    k. 11=Other (please specify)
    l. 12=No, none of these

20. If you were experiencing severe emotional distress, whom would you talk to about this?
    a. 1=Professional clinician (e.g., psychologist, counselor, or psychiatrist)
    b. 2=Roommate
    c. 3=Friend (who is not a roommate)
    d. 4=Significant other
    e. 5=Family member
    f. 6=Religious counselor or other religious contacts
    g. 7=Support group
    h. 8=Other non-clinical sources (please specify)
    i. 9=No one

The teenagers will take the anonymous survey in classroom A on a Sunday after the second service. Once the data has been collected, the researcher will compile the data using a computer-generated program such as Atlas. ti to transcribe and code the data. After the data has been gathered, the second step of the research begins.

With the complete list of the leaders, the researcher will contact the leaders individually and request that they participate in the mental health awareness training using the verbal recruitment form. The training will begin and end with an assessment to measure the growth along the way. The mental health awareness training will end with a brief debrief secession. Next, the researcher and the leaders will establish a time and place at the church for the leaders to meet each week for four consecutive weeks- Three weeks of training and one week to discuss the impact of the training and ways forward for the ministry. During the final secession (Week 4), the leaders will determine what the church is doing well and other areas where the church needs development.

Due to COVID, in-person training might be difficult because the church hosts meetings virtually to meet social distancing guidelines. A Zoom option will be available for the people who may not make it in person. On the first day of training, the leaders will take a pre-assessment to gather primary data regarding prior knowledge regarding adolescent mental health concerns. The answers provided will be analyzed and compared to the post-assessment. These questions will ask:

1. What are the four main types of mental health problems?
2. Have you ever personally experienced a mental health problem, or has someone in your family shared one?
3. How confident do you feel in helping someone with a mental health problem?
4. Have you contacted anyone with a mental health challenge in the last year?
5. Have you ever utilized websites to research care for the mentally ill or read several books on counseling mental illness?

6. How would you rate your comfort level in interacting with an individual experiencing a mental health crisis?
7. What is your perception of mental health?
8. Would the church benefit from having a counseling center open to the community?

The training will be held consecutively for three Saturday mornings from 9:00 am until 12:00 noon at the church. The purpose of the mental health training will be to equip the church leadership to assist as a lay-leader with those adolescents experiencing mental health crises. The training will involve components addressing the risk factors and warning signs regarding psychological, physical, and emotional symptoms in the youth experiencing mental health challenges who attend the church. Then strategies will be discussed addressing how to provide short-term support in basic listening skills and crisis intervention.

Weekly Training Sessions (First three weeks)

Week 1- What is Mental Health?

- Pre-Assessment
- Review data and shows statics from the survey with teenagers
- What is Mental Health?
- Mental Health Problems in the USA
- The stigma of mental illness
- Listening skills
- Video about mental illness
    - VIDEO: Mental Health Awareness and DeEscalation: PACER Integrative Behavioral Health

Week 2- Depression and Anxiety

- Depression and Anxiety Disorders
    - Reflection Worksheet Directions: Think of a time in your life when you felt depressed, sad, or blue. Take 5-10 minutes to answer the following reflection questions.
        1. Generally, what was the situation?
        2. Who was involved?
        3. Where did it happen?
        4. When did it happen?
        5. Make a list of words that describe how you felt when you were sad.
        6. Did you act differently during this time? Describe this.
        7. Did you think differently during this time? Describe this.
- Depression and anxiety Characteristics, symptoms, and risk factors
- Guest speaker to talk about depression and anxiety
- Experiences of mental illness
- Bible figures who struggled with depression
    - David
    - Elijah
    - Jonah
    - Job
    - Moses
    - Jeremiah
- Group sessions – Choose three questions to discuss
    - Share a few of the words or feelings associated with depression? What are some of the actions often associated with depression?
    - Share a definition of depression in your own words? What causes depression?

- Clinical depression is a term that is used when a person feels depressed for long periods. Share reasons why depression is severe.
- Being sad or disappointed when things seem to go wrong is a natural feeling to have. These feelings generally do not last for long periods. Not being selected for an athletic team or a leading role in a school play would disappoint most individuals. How do teens generally deal with these types of situations?
- Why is it sometimes hard to tell if a person is depressed? Keeping an image of being a fun-loving, outgoing, and confident person may be concealing a person's real feelings of depression. Share some of the "feelings of depression" are from our vocabulary terms?
- Anger, resentment, and feelings of hopelessness or helplessness are warning signs. Recognizing these feelings is an essential first step to take. Would you feel comfortable in asking one of these people for help if you needed it? Why or why not? List out some ways to help students in crisis situations?
- What are some of the everyday situations teens experience that cause higher than normal anxiety or stress levels? Why?

- Videos about depression and anxiety

Week 3- Mental Health and Family

- Mental Health and adolescents
- Mental Illness and the Importance of Family Communication
- Seeking Help and Finding Support in the community
    - Johannah Song - (682) 253-6780

    - Rayne L. Ventimiglia Clinical Social Work/Therapist, LCSW (817) 402-2419
    - National Suicide Prevention Lifeline: 800-273-8255

- The Importance of Positive Mental Health
- In Crisis Situations – Action plan
- Group sessions- Various Scenarios

Week 4- Follow-up session to discuss the results

- What would you like to see in the future
- What have you learned in these past three weeks
- Talk about the pre-assessment and post-assessment results
- Offering a program to the parents

After the three weeks of presenting an assortment of lectures, training, and numerous question and answer sessions, the leaders will then take a post-assessment to determine whether or not any improvements were made. The end goal of the training is for the various individuals to recognize and identify the signs and symptoms of mental disorders. At the same time, educating leaders about available resources in the community for individuals with a mental illness. These questions will ask:

1. What does mental health mean to you?
2. How confident do you feel in helping someone with a mental health problem?
3. What are the four main types of mental health problems?
4. How would you rate your comfort level in interacting with an individual experiencing a mental health crisis?
5. What is your perception of mental health?
6. Would the church benefit from having a counseling center open to the community?

The researcher will then compile the participant responses ascertaining their view of adolescent mental health. During the post-assessment, the researcher will seek voluntary, informal feedback from the participants regarding ideas for continuing education. The hope here is to gather data on how to effectively educate leadership, workers, and members within the church, thus creating a safe haven to address adolescent mental health needs.

In his book, Qualitative Research, Sensing describes data analysis as the process of bringing order, structure, and meaning to the complexity of qualitative data that the researcher produces during the research process.[97] The researcher will keep a journal with detailed and specific impressions of the daily research during the research process. The researcher will use observations from outsiders, the teenagers, the parents, and as many people involved to build the data. All data collected will be analyzed through atlis.ti. The researcher is aware that qualitative analysis requires creativity to an extent. The challenge at hand is to find a way to communicate the interpretation of the raw data to others.[98] Once the researcher has laid out the data collected, creating an understanding would follow through. The purpose of the chapter was to describe the methods and procedures the researcher applied to answer the posed research questions.

[97] Sensing, *Qualitative Research*, 194.

[98] Sensing, *Qualitative Research*, 194.

CHAPTER 4: RESULTS

As mentioned earlier in this research, mental disorders account for a large percentage of the illness burden in young people in all cultures. Though they are often first identified later in life, mental disorders begin during youth (12-24 years).[99] Research also proves that poor mental health is deeply connected with other health and development concerns in young people, notably lower educational attainments, substance abuse, violence, and health. In addition, young people have a high rate of self-harm, and suicide is the leading cause of death among young people.[100] There is a wide range of evidence to show that mental disorders in young people have increased drastically during the past few decades.[101]

Depression is the most experienced mental health problem by teenagers today, and it expresses itself in numerous ways and to various levels. Depression is distinguished by several indicators, feelings of sadness, desolation, unexplained tiredness, and fatigue. It could be the feeling that even the most minor tasks are almost impossible, a loss of appetite for food or company, and excessive worry. Feeling like a failure, unjustified feelings of guilt, feelings of worthlessness, or hopelessness. Sleep difficulties and physical symptoms such as back pain or stomach pains, loneliness, and low self-esteem are risk factors for depression. [102] The alarming increase in rates of depression and suicide is not only in the United States but globally. Research shows that suicide is a prominent cause of death in young people in countries such as China and

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[99] Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Adolescent Health 3: Mental health of young people: a global public-health challenge. The Lancet, 369(9569), 1302-13.

[100] WHO. Child and adolescent mental health policies and plans. Geneva: World Health Organization, 2005.

[101] Fombonne E. Depressive disorders: time trends; and possible explanatory mechanisms. In: Rutter M, Smith DJ, eds. Psychosocial disorders in young people: time trends and their causes. Chichester:Wiley, 1995.

[102] National Alliance for Mental Health. (2016). Why self-esteem is important for mental health. Retrieved from https://www.nami.org/Blogs/NAMI-Blog/July-2016/Why-Self-EsteemIs-Important-for-Mental-Health

India. An Indian study determined that the cause of death of children ages 10-19 in a rural society in India was suicide.[103] People's responses to adverse situations are shaped by early life experiences,[104] which is why attention must be given to children from a young age.

The stigma of mental illness is predominant in society today and has negative consequences for individuals, families, and friends.[105] The shame society correlates with mental health disorders is one of the significant reasons many individuals do not seek therapy despite the substantial improvement of mental health treatment services over the past 50 years.[106] Different interventions to reduce mental health stigma exist. Pertinent research has confirmed that non-direct communication methods such as educational videos effectively reduce stigma towards mental illness and spread awareness.[107] It is suggested that these video training are more efficient in reducing mental illness stigma when processed in groups than individually. These group experiences allow participants to be more engaged with other participants by listening, providing feedback, and discussing mental health issues.[108]

Some of the main challenges to addressing mental-health needs presently include the shortage of mental-health specialists, the low capacity and motivation of non-specialist health

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[103] Aaron R, Joseph A. Abraham S, et al. Suicides in young people in rural southern India. Lancet 2004; 363:1117-18.

[104] Walker SP. Chang SM, Powell CA. Simonoff E, Grantham-McGregor SM. Effects of psychosocial stimulation and dietary supplementation in early childhood on psychosocial functioning in late adolescence: follow-up of randomized controlled trial. BMJ 2006; 333:472.

[105] Rusch, N., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. European Psychiatry, 20, 529-539.

[106] Corrigan, P. W., Watson, A. C. & Miller, F. E. (2004). Shame, blame, and contamination: The impact of mental illness and drug dependence stigma on family members. Journal of Family Psychology, 20(2), 239-246.

[107] Corrigan, P. W., & Shapiro, J. R. (2010). Measuring the impact of programs that challenge the public stigma of mental illness. Clinical Psychology Review, 30, 907-1022.

[108] Abrams, D., & Hogg, M. A. (1990). Social identification, self-categorization and social influence. In W. Stroebe & Hewstone (Eds.), European Review of Social Psychology (pp. 195-228). Chichester, England: Wiley.

workers to provide quality mental health services to young people, and the stigma associated with a mental disorder.[109] Addressing the mental health needs of teenagers is crucial if they are to accomplish their potential in life accurately. Research shows that training lay people to deliver mental health interventions in the community can be a successful strategy to spread mental health awareness and render substantial assistance to communities.[110] Lay people are ordinary, regular people in the community and possibly serve in a church. The current crisis the USA is currently facing is the high demands for services, workforce shortages, and diminishing organizational resources. The difficulty is not about the quality of care but access to qualified mental health professionals and facilities.[111]

Bridges to Care and Recovery program encourages the behavioral health assessment, treatment, and recovery of individuals through partnerships with churches in the African American community. Church members receive mental health training and skill-building, enabling and equipping them to serve as personal mental health educators and advocates. A Community Connector provides counseling and recommendations to behavioral health services, including access to free counseling. This reduces stigma and strengthens relationships between behavioral health service providers and the community.[112]

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[109] Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. Adolescent Health 3.

[110] Iheanacho, T., Nduanya, U. C., Slinkard, S., Ogidi, A. G., Patel, D., Itanyi, I. U., Naeem, F., Spiegelman, D., & Ezeanolue, E. E. (2021). Utilizing a church-based platform for mental health interventions: exploring the role of the clergy and the treatment preference of women with depression. Global mental health (Cambridge, England), 8, e5.

[111] Cohen Veterans Network, America's Mental Health. (2018).

[112] Scribner, S. S., Poirier, R. F., Orson, W., Jackson-Beavers, R., Rice, B. T., Wilson, K., & Hong, B. A. (2020). Bridges to Care and Recovery: Addressing Behavioral Health and Mental Health Needs Through the Faith Community. Journal of Religion and Health, 59(4), 1946-1957.

Addressing the problem of Arise and Shine International Ministries of teenagers struggling with mental health and not receiving adequate counseling or support due to cultural stigma had its challenges, but it was successful. The study results were designed to provide actionable recommendations for the leaders in ASIM to consider assisting those in need.

The researcher obtained permission to research the church on the 17th of September. Then, announcements were sent out to families regarding the research stating: "An announcement will be made on Sunday regarding an opportunity to participate in a research study. If you are interested, please attend the first and second service on 10/19/2021." After the announcement was sent out to families through text, a few parents and teenagers expressed interest and asked questions. On the 19th during general church announcements, the researcher stated the following.

> Hello ASIM Families,
>
> As you know, I am a graduate student in the School of Ministry at Liberty University. I am researching as part of the requirements for a Doctorate degree. The purpose of the study is to conduct a research study on how adequate counseling can drastically transform teenagers struggling with mental illness. The goal is to provide an awareness of mental illness within the church and create support for those in need. Creating awareness helps break the stigma that encourages people to get help. If you meet my participant criteria and are interested, I invite you to join my study. Participants must be 13-18 or a leader in Arise and Shine International Ministries. Participants, if willing, will be asked to attend a 3-day training (3 hours) for the leaders and fill out a 30-minute survey for the teenagers. Participation will be completely anonymous, and no personal, identifying information will be collected.

If you would like to participate, please join me in classroom C immediately after this service. If you are a teenager, you must attend with your parent. Thank you for your time. Before the meeting, the researcher had a sign-in sheet at the door. To protect the identity of everyone, the parents were not required to write their names, as shown below.

Mental Health Awareness Survey

Number of Participants	Is the parent Present (Yes or no)	Is the participant present (Yes or no)
1.	✓	✓
2.	Yes	Yes
3.	YES	YES
4.	Yes	Yes
5.	✓	✓
6.	Y	Y
7.	Yes	Yes
8.	Quinn	Quinn
9.	Yes	Yes
10.	yes	yes
11.	YES	YES
12.	Yes	Yes
13.	✓	✓
14.	yes	yes
15.	Yes	Yes
16.	Y	Y
17.	Yes	Yes
18.	Yes	Yes
19.	Yes	Yes
20.	YES	YES

The researcher asked the parents and participants what they thought mental health was; here are some responses.

1. I do not know
2. How someone is feeling mentally
3. Your well-being in your mind also plays a big role in one's life.

4. The health of a person’s mind and relation to others.
5. The condition and state a person's brain is in. Mental health is the emotional well-being of an individual.
6. Mental health is a foundation that can and will affect every aspect of one’s life.
7. The state of stability and or happiness a person is in.

The researcher then explained briefly that mental illnesses are health conditions that interrupt and disturb a person’s thoughts, emotions, relationships, and daily functioning. They are linked with distress and a weakened capacity to engage in the ordinary activities of everyday life. Mental illnesses fall along with a range of seriousness: some are moderately mild and only affect some aspects of life, such as specific phobias. As believers, we know that Jesus came to earth and died to comfort us in all our afflictions, including mental illness. The goal and purpose of this research are to show the need for counseling in the church. Now is the time for the church to recognize and admit that mental illness exists and to minister accordingly.

The researcher explained that the individual's participation is voluntary and anonymous. The first step was to attend the recent meeting; the second step was to fill out a questionnaire the upcoming Sunday. The researcher then passed out the consent form and proceeded to read and explain it to the parents. The parents asked a few questions, one of which was, “How am I sure that my child will not be identified.” The researcher explained that each participant would use the same pen color; nothing on the survey required them to include their name. Once they are done, they will turn their paper into a file upside down. The researcher will then upload the anonymous documents to ATLIS.TI, where they would be coded and analyzed. After the meeting, the parents signed the consent form. The participants agreed to meet on the 26th after the service in the same classroom, C.

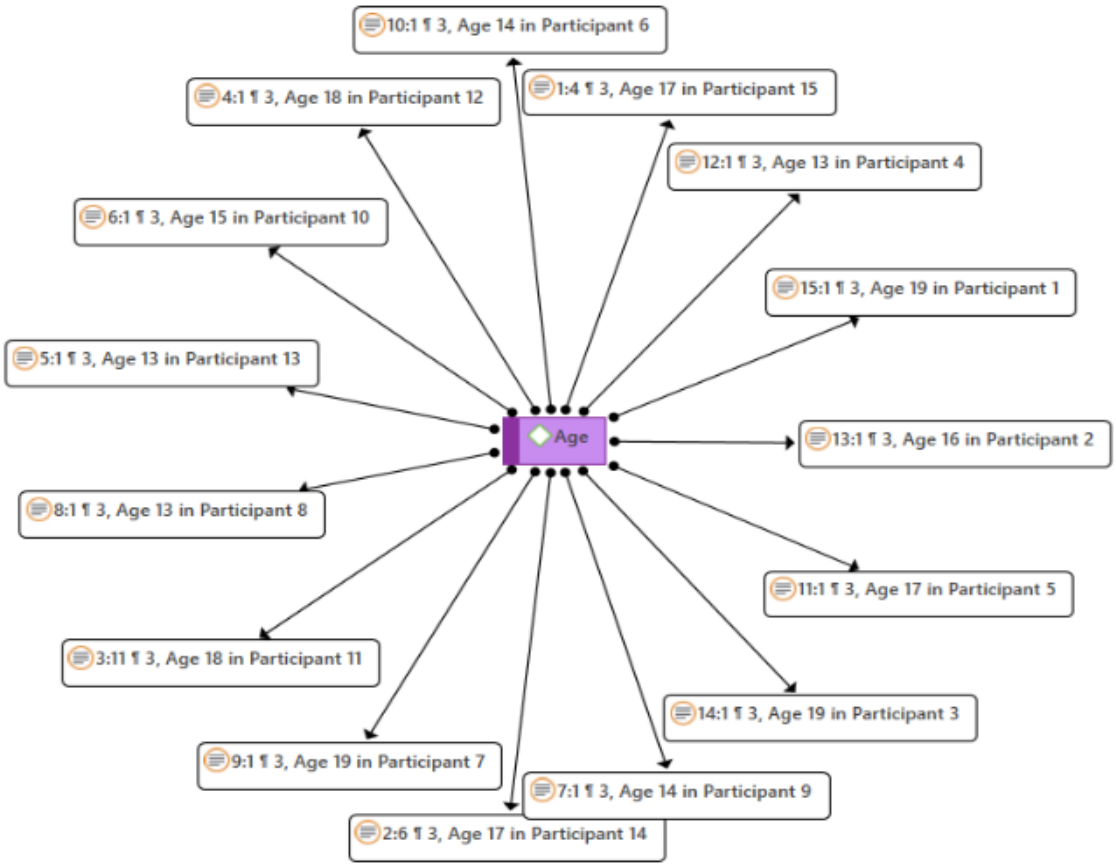
Of the twenty parents and families attending the meeting, six declined to participate in the survey. During the week, the researcher sent a reminder to the participants about their upcoming questionnaire. During the week, a final participant signed the consent form and indicated interest. On Saturday, the researcher made 16 copies of each survey, bought a pack of pens and a box of large manila envelopes. The researcher then put one survey and one pen into the envelope, took them to church, and locked them in a secure safe box.

On Sunday, during the announcements, the researcher spoke specifically to the leaders. Restating the goal is to provide an awareness of mental illness within the church and create support for those struggling with mental illness. The researcher mentioned that the participant for the training must be in a leadership position in Arise and Shine International Ministries. They must be willing to attend a 3-day training (3 hours). If they are interested, they need to meet in classroom B before 1 pm. Sixteen leaders came to the meeting; the researcher explained that the goal was to set a time on Saturday that was feasible for everyone. After much debate, the leaders did not feel comfortable coming to church due to COVID. Two leaders left, saying their Saturdays were already booked and could not take on another responsibility. The leaders mentioned their dilemma to the lead pastor, who suggested having the training via Zoom instead. The entire team concurred, a new leader came in and joined the training, completing the 15 mark. The leaders were aware that the researcher would send the Zoom links and training materials before the first session, the 2nd of October.

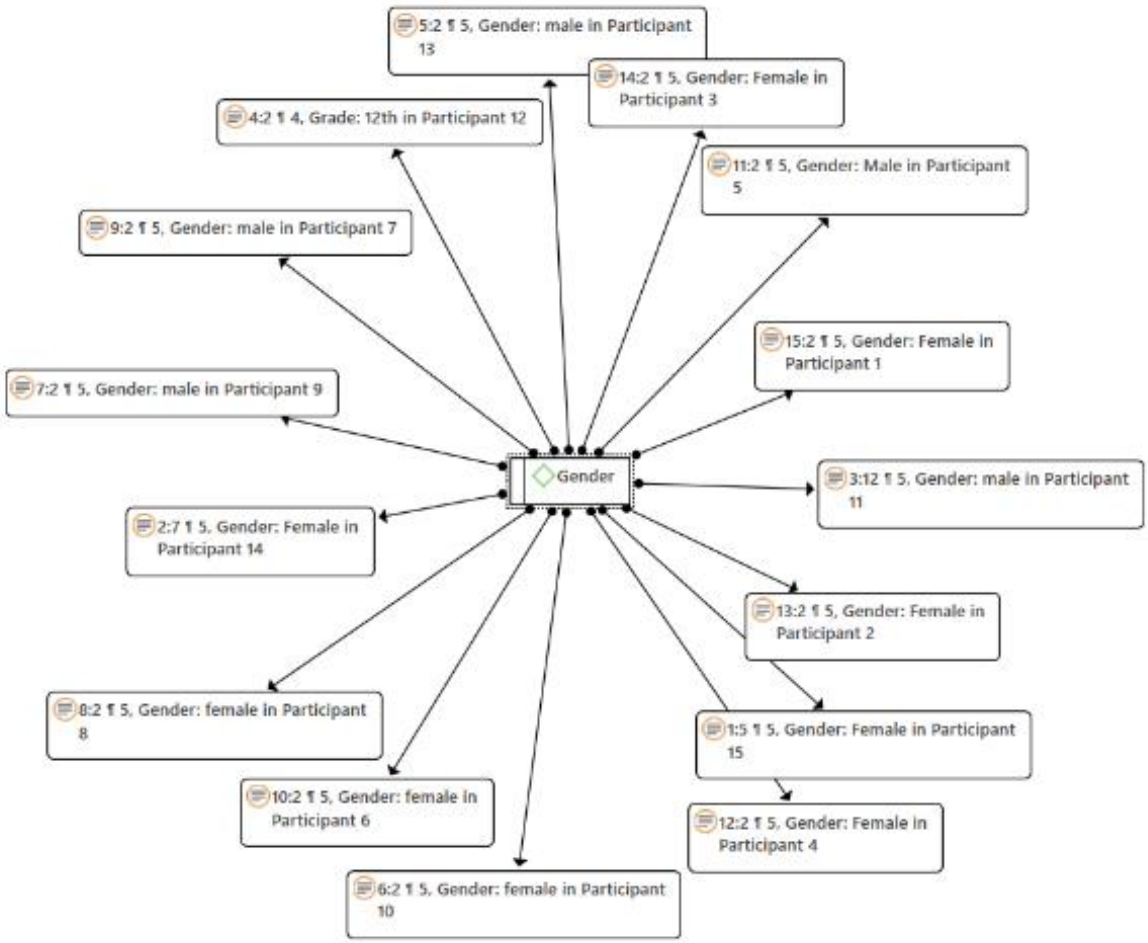
Once the meeting with the leaders was over, the researcher provided snacks for the participants (teenagers) before taking the survey. Once it was 1:30 pm, the participants entered the classroom; the researcher gave them their envelope as they came in. Once they were seated, the researcher explained that they were allowed to withdraw at any time, even after they began

the survey. The researcher said they need to put it back into the manila envelope, turn it in, and leave once they are done.

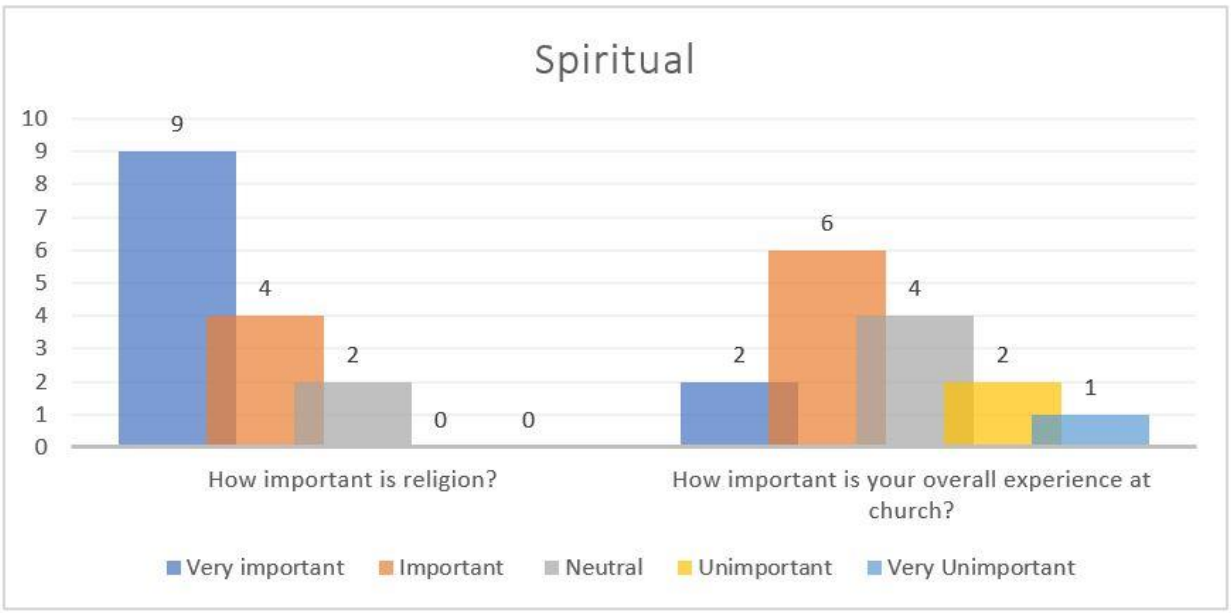
After the survey was conducted and turned in, the researcher evaluated the fifteen surveys using ATLIS. TI. The ages of the fifteen participants varied from 13 to 19 years old, as shown below.



Out of the fifteen participants, 9 were females, 5 were males, and one was unknown, as shown on the graph below. All the participants were African Americans, specifically of Nigerian descent. With the age range, the participants range from first-year students in high school to college sophomores.



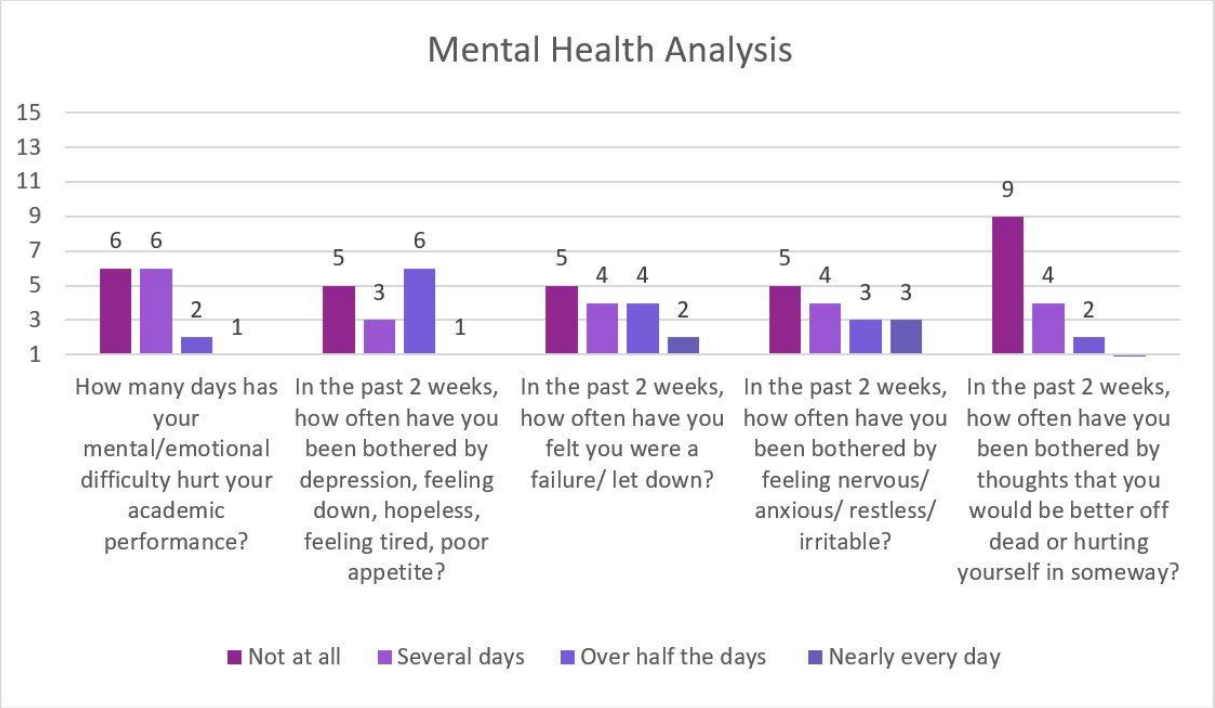
The survey consisted of twenty multiple-choice questions. The first two questions focused on how important the participant believed religion to be and how important the church was to them. In analyzing the responses of the participants, the researcher noticed a few similarities and differences. The first graph shows the answers; most participants expressed that religion/ spirituality was essential to them. However, there was a decline when asked how important their experience was at their current church. This is a crucial point to take down. If the teenagers don't view their present church as essential and are not satisfied, it would be challenging for them to ask for help.

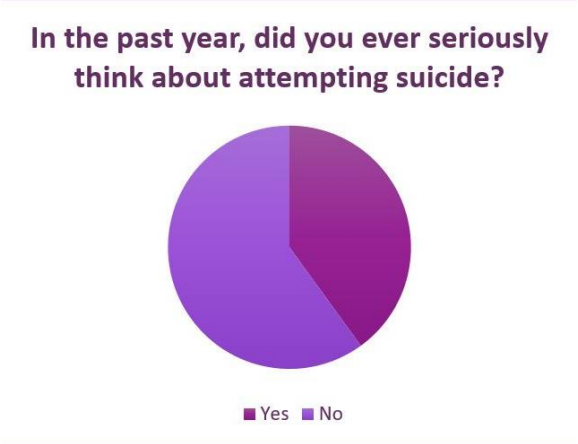


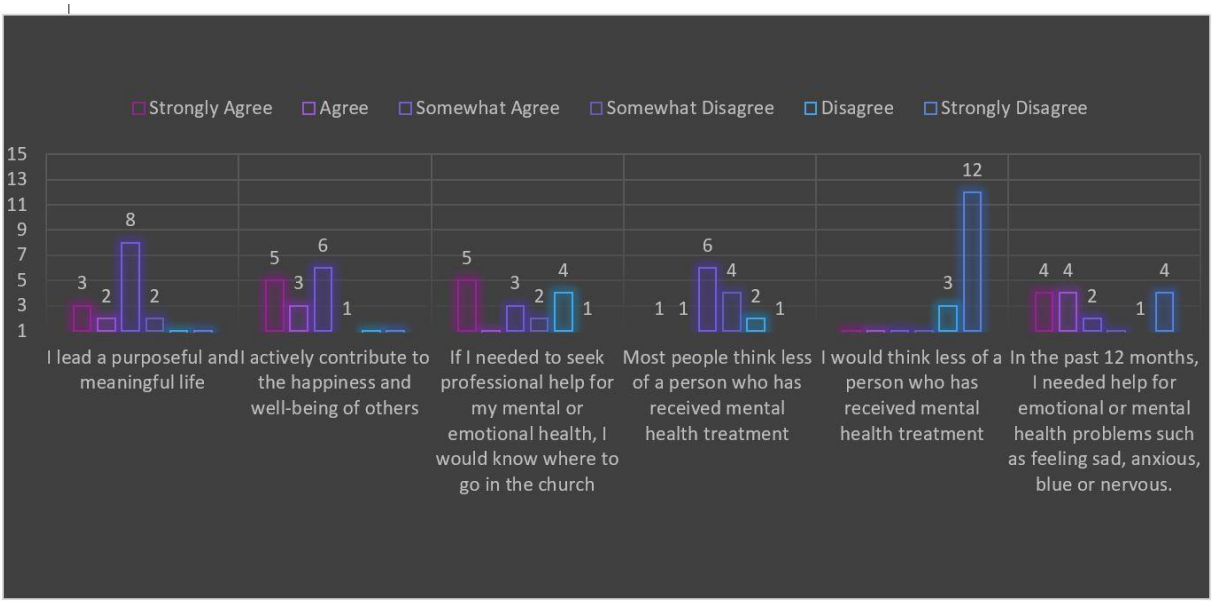
The survey proceeded to ask personal questions focusing on the mental health of the participant. According to the National Institute of Mental Health, if a person has been experiencing any of these signs and symptoms for at least two weeks, they may be suffering from depression. Symptoms include persistent sadness, anxiety, or "empty" mood, feelings of hopelessness, irritability, guilt, worthlessness, or helplessness, decreased energy, or fatigue. Difficulty sleeping, early-morning awakening, or oversleeping, loss of interest or pleasure in hobbies and activities. Difficulty concentrating, changes in appetite or weight, thoughts of death or suicide, suicide attempts and aches or pains, headaches, cramps, or digestive problems without a clear physical cause that does not ease even with treatment.[113]

[113] U.S. Department of Health and Human Services. (2020). Depression in women: 5 things you should know. National Institute of Mental Health. Retrieved October 27, 2021, from https://www.nimh.nih.gov/health/publications/depression-in-women.

Below are the results of those questions. According to these results shown and the description from the National Institute of Mental Health, many teenagers in ASIM could be suffering from depression. Sadness is only a small part of depression. Some people with depression do not feel sadness at all. These numbers prove that though it is not clinically proven, some teenagers possibly need counseling.







The final two questions specifically asked, “Have you ever done any self-harm intentionally in the past year.” Six participants (Participant 1, 4, 6, 8, and 14) indicated that they have either punched or banged themselves, pulled their hair to inflict pain, cut themselves, bit themselves, punched or banged an object to hurt themselves, scratched and or interfered with wound healing. These 6 participants are among the people that marked they were not satisfied with their mental stability. They indicated that their emotional and mental difficulties had hurt their academic performance several and nearly every days. These six participants expressed that they have been bothered by depression, little interest, feeling down, depressed, or hopeless, feeling tired, feeling bad about themselves, or feeling like a failure and let down over the last two weeks. They circled either nearly every day or over half the days. They all indicated that in the past year, they have seriously thought about attempting suicide. Another similarity found they were asked if they needed professional help for their emotional or mental health, would they know where to go? They all strongly disagreed with the question, which speaks volumes. They all agree that counseling is indeed helpful but unaware of where to get this help.

The final survey question was if they were experiencing severe emotional distress, whom would they talk to about it. Six people indicated no one; eight stated a family member, and one said a professional clinician. None of the 15 participants felt the church was equipped enough to help them through their emotional and mental problems. After completing the first step of the research, the researcher is ready to begin the training with the leaders. Before the first training, the researcher sent the Zoom link to the trainees, prepared the curriculum and training lesson plan for the three-week teaching.

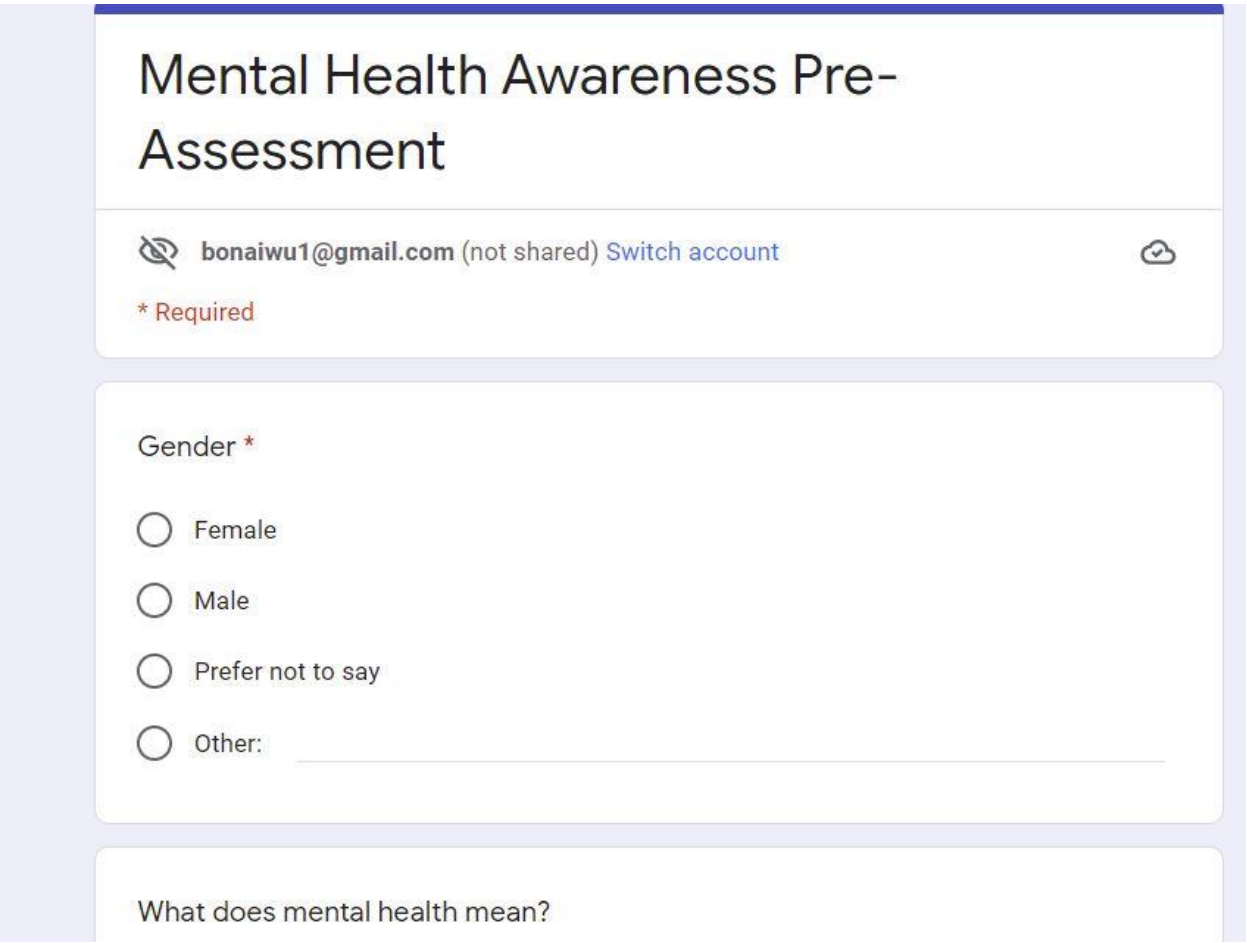
Training Week 1

Pre-Assessment

On the 2nd of October, the participants logged in; they were very enthusiastic about the training. Very few of the leaders had an idea of what mental illness was. Their excitement possibly came from learning something new. The training began at 9 am with a pre-assessment.

The researcher sent a link to the trainees in the Zoom group chat and asked everyone to fill it out. The researcher proceeded to set a 15-minute timer to alert them once it was time. After the assessment, the researcher asked the leaders what they believed mental illness meant. Below are a few of their responses.

1. A lot of the leaders did not know what mental illness truly meant.
2. Mental illness is not a good thing, and as children of God, we should not condone it
3. Mental illness is the state in which our mind is in, which could damage the individual.
4. Mental illness is when a person does not take care of their mind



Review Data

The researcher provided the leaders with the results from the survey previously conducted. The researcher went through each question and the responses from the 15 participants. The leaders were shocked; they did not realize how many teens within their reach needed help. They also mentioned, if only one teenager suffered from depression, it was more than enough to render assistance.

What is Mental Health?

According to the American Psychiatric Association, mental illnesses are health conditions involving changes in emotion, thinking, or behavior (or a combination of these). Mental illnesses are associated with distress and problems functioning in social, work, or family

activities.[114] Mental illness is widespread today; it is a medical problem, just like heart disease or diabetes. Each year: Nearly one in five (19 percent) U.S. adults experience some form of mental illness. One in 24 (4.1 percent) has a severe mental illness. One in 12 (8.5 percent) has a diagnosable substance use disorder.[115] The WHO constitution states: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." [116]

VIDEO: Mental Illness Causes, Symptoms, Diagnosis, and Treatment. [117]

Mental Health Problems in the USA

In the United States today, substance use and mental health issues affect millions of adolescents and adults.[118] According to research, the ambiguities and fears correlated with the COVID, mass lockdowns, and economic recession are anticipated to increase suicide and various mental illnesses.[119] Adolescence is defined as an intermediate phase between ages 10 and 19.[120] People generally perceive this phase of life is passed with no health problems. However,

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[114] Parekh, R. (2018). What Is Mental Illness? American Psychiatric Association. Retrieved October 26, 2021, from https://www.psychiatry.org/patients-families/what-is-mental-illness.

[115] Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., Swendsen, J. Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication- Adolescent Supplement (NCS-A). J Am Acad Child Adolesc Psychiatry. 2010 Oct;49(10):980-9.

[116] Strengthening Mental Health Promotion external icon. Fact sheet no. 220. Geneva, Switzerland: World Health Organization.

[117] Merck Manuals. (2020, August 24). Mental Illness Causes, Symptoms, Diagnosis, and Treatment | Merck Manual Consumer Version [Video]. YouTube. https://www.youtube.com/watch?v=-squqwaTuxo

[118] Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health. Rockville, MD: Center for Behavioral Health Statistics and Quality. Substance Abuse and Mental Health Services Administration. 2016.

[119] McIntyre R.S., Lee Y. Projected increases in suicide in Canada as a consequence of COVID-19. Psychiatry Res. 2020;290.

[120] World Health Organization. *Adolescence: The Critical Phase*. World Health Organization; 1997.

approximately 20% of adolescents experience a mental health problem, most commonly depression or anxiety.[121] Childhood and adolescence are crucial periods to promote mental health awareness. More than half of mental health problems start at these stages, which persist throughout adult life.[122]

The stigma of mental illness

Public stigma involves the negative or discriminatory attitudes that others have about mental illness. Stigma often comes from a lack of understanding, fear, wrong or deceptive media interpretations of mental illness.[123] More than half of people with mental illness do not get the needed for their disorders due to stigma. Stigma obstructs care-seeking and destabilizes the service system.[124] It directly affects people with mental illness and their support system, provider network, and community resources in diverse ways.[125] Understanding stigma and creating awareness about mental illness is fundamental to diminishing its negative impact on society.

[121] World Health Organization. Adolescent mental health—Mapping actions of nongovernmental organizations and other international development organizations WHO World Heal Organ; 2012;50.

[122] Kessler R. C., Berglund P., Demler O., Jin R., Merikangas K. R., Walters E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. Arch. General Psychiatry 62, 593–602.

[123] The American Psychiatric Association

[124] Abdullah, T., Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. Clinical Psychology Review, 31, 934–948.

[125] Anglin, D. M., Link, B. G., Phelan, J. C. (2006). Racial differences in stigmatizing attitudes toward people with mental illness. Psychiatric Services, 57, 857–862.

Listening skills

The participants will then watch a video lesson about listening skills- YouTube Video: 5 ways to listen better, TED Talk by Julian Treasure.[126]

According to West and Turner, listening is more than the passive act of receiving or hearing. It is the deliberate processing of the auditory stimuli that have been perceived through hearing.[127] Listening is an active process to listen to what the speaker is saying without planning a response. In the video we just watched, Julian Treasure noted that humans are losing their hearing due to their inability to listen completely. Listening is our access to understanding, and conscious listening creates understanding. Active listening is more than just paying attention to what is being said. It is a technique that's used in counseling, training, and solving disputes or conflicts. It is a vital relational skill that requires the listener to fully concentrate, understand, reply, and recall what is being said.[128] Here is a list of the most common mistakes made when listening to other people:[129]

1. Daydreaming or thinking of something else
2. Thinking of what to say next
3. Judging what the other person is saying
4. Listening with a specific goal/outcome in mind.

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[126] TED Talk. (2011, July 29). 5 ways to listen better | Julian Treasure [Video]. YouTube. https://www.youtube.com/watch?v=cSohjlYQI2A.

[127] West, R., & Turner, L. H. (2010). Understanding Interpersonal Communication (Vol. 2nd Edition). Boston, USA: Cengage Learning.

[128] Rogers, C. R., & Farson, R. E. (1957). Active Listening. Chicago, USA University of Chicago. Industrial Relations Center.

[129] Ucok, O. (2006). Transparency, communication, and mindfulness. Journal of Management Development, 25(10), 1024-1028.

These errors are clear signs that the words the people are saying are not being heard. An individual's ability to listen directly affects their ability to understand and empathize with others.[130] Words matter, and without active listening, it is challenging to explore a person's actual feelings and thoughts.

Training Week 2

Depression Disorders

The American Psychiatric Association defines depression as more than just feeling down or having a bad day. Depression is when a sad mood lasts for a long time and restricts a person's everyday functioning.[131] The exact cause of depression is undetermined. Depression can be caused by a combination of genetic, biological, environmental, and psychological factors. A few examples of what can increase a person's chances have blood relatives who have had depression, experiencing traumatic or stressful events, such as physical or sexual abuse, the death of a loved one, or financial problems, and going through a significant life change.[132] About 1 out of every six adults will have depression at some stage in their life.[133] This is why creating awareness about mental illness is essential.

[130] Fredrickson, B. L., & Joiner, T. (2002). Positive Emotions Trigger Upward Spirals Toward Emotional Well-Being. Psychological Science (Wiley-Blackwell), 13(2), 172.

[131] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA: American Psychiatric Publishing, 2013.

[132] Belmaker, R. H., Agam, G. Major Depressive Disorder. New England Journal of Medicine 2008; 358: 355–68.

[133] Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry 2005;62(6):593-602.

Anxiety Disorders

Anxiety disorder is a group of mental illnesses that cause constant and tremendous anxiety and fear. Excessive anxiety can make people avoid work, school, family get-togethers, and other social situations that might activate or worsen their symptoms.[134]According to the Anxiety and Depression Association of America, anxiety disorders are the most common mental health problem among U.S. adults, affecting 18.1 percent of the population each year. And mood disorders are the primary cause of disability.[135] Frequently, anxiety disorders begin in childhood or adolescence.[136] The World Health Organization ranked anxiety disorders in sixth place among all mental and bodily illnesses worldwide. They are additionally among the chronic diseases with the most significant impact on patients' lives.[137]

Reflection Worksheet Directions

Think of a time in your life when you felt depressed, anxious, or sad. Take 5-10 minutes to answer the following reflection questions, then write down the answer:

1. Generally, what was the situation?
2. Who was involved?
3. Where did it happen?
4. When did it happen?

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[134] Bystritsky, A., Khalsa, S. S., Cameron, M. E., & Schiffman, J. (2013). Current diagnosis and treatment of anxiety disorders. P & T: a peer-reviewed journal for formulary management, 38(1), 30–57.

[135] Patriquin, M. A., & Mathew, S. J. (2017). The Neurobiological Mechanisms of Generalized Anxiety Disorder and Chronic Stress. Chronic Stress.

[136] Beesdo K, Pine DS, Lieb R, Wittchen HU. Incidence and risk patterns of anxiety and depressive disorders and categorization of generalized anxiety disorder. *Arch Gen Psychiatry.* 2010; 67:47–57.

[137] WHO. Depression and Other Common Mental Disorders: Global Health Estimates. Geneva: World Health Organization; 2017. http://apps.who.int/iris/bitstream/handle/10665/254610/WHO-MSD-MER-2017.2-eng.pdf;jsessionid=829EAD6A4E0473EBDE28F4FD23B8D556?sequence=1).

5. Make a list of words that describe how you felt when you were sad.
6. Did you act differently during this time? Describe this.
7. Did you think differently during this time? Describe this.

After the 10-minute times' rings, the researcher told the trainees that they would be in groups. In their group, they would need to each speak about their reflection. The researcher gave them an additional 10 minutes and put them in five different breakout groups with three people. After the group discussion, the researcher asked two volunteers to share their experiences with the entire group. The researcher noticed how most of the trainees were eager to share their experiences, though they previously mentioned they had never suffered depression.

Depression and anxiety- Characteristics, symptoms, and risk factors

Within the week, the researcher spoke to multiple counselors in the community of Bedford with the hopes of having one be a guest speaker at the training. Positive Pathways Counseling agreed to send a guest speaker to talk about depression and anxiety for 30 minutes. The Guest speaker is a licensed Professional Mental Health Counselor. She spoke and enlightened the trainees about depression and anxiety. She specifically focused on the characteristics, symptoms, and risks factors.

Bible figures who struggled with depression

David

Evaluation of the Bible reveals that David indicated that he had some mental disorder, and among the many possibilities, major depression, dysthymia, and minor depression are the most likely. Of these diagnoses, major depression seems the most acceptable. He wrote of his grief, loneliness, fear, and guilt in many Psalms because of his sin. In 2 Samuel 12:15-23 and 2

Samuel 12:18-33, he grieved over the loss of his sons.[138] David's emotions were up and down, up and down. One minute he's going off praising God, and the next, he was asking God, "Where are You?" Yet God called him "a man after his own heart" (1 Samuel 13:14).

Elijah

Elijah, a prophet, Biblical hero, and person of faith, was seriously depressed. In 1 Kings 18-19, he felt hopeless, alone, and afraid instead of Elijah feeling victorious. Elijah had low self-esteem and wanted to die. In 1 Kings 19:4, he prayed for death, asked the Lord to take him; he no longer wanted to be alive. He tried to sleep and had to be encouraged to get up and nourish himself.[139]

Some of the other Bible examples who had a mental illness were Jonah, Job, Moses, Jeremiah. Though they battled with these illnesses, they were able to activate the gift within them and serve in the body of Christ for God.

Group sessions – Choose three questions to discuss

To conclude week two's training, the researcher presented ten questions to the leaders and told them they had fifteen minutes to discuss 2-3 questions. The researcher put them into five groups, with three participants in each group. Once the time was up, they addressed each question as a group. By this time, the researcher begins to see a high level of growth from the leaders. They already had a newfound appreciation for the study. They were able to retain the training from the previous week, as well as the current week. The question-and-answer session

[138] Ben-Noun L. (2004). Mental disorder that afflicted King David the Great. History of psychiatry, 15(60 Pt 4), 467–476.

[139] McDaniel, Debbie, 4 May 2016, Crosswalk.com "7 Bible Figures Who Struggled with Depression," available: http://www.crosswalk.com/faith/spiritual-life/7-bible-figures-who-struggled-with-depression.html – accessed October 12, 2021.

went over the 3-hour time limit. Some of the leaders stayed after the training for an additional 15 minutes.

1. Share a few of the words or feelings associated with depression?
2. What are some of the actions often associated with depression?
3. Share a definition of depression in your own words? What causes depression?
4. Clinical depression is a term that is used when a person feels depressed for long periods. Share reasons why depression is severe.
5. Being sad or disappointed when things seem to go wrong is a natural feeling to have. These feelings generally do not last for long periods. Not being selected for an athletic team or a leading role in a school play would disappoint most individuals. How do teens generally deal with these types of situations?
6. Why is it sometimes hard to tell if a person is depressed?
7. Keeping an image of being a fun-loving, outgoing, and confident person may be concealing a person's real feelings of depression. Share some of the "feelings of depression" are from our vocabulary terms?
8. Anger, resentment, and feelings of hopelessness or helplessness are warning signs. Recognizing these feelings is an essential first step to take. Would you feel comfortable asking one of these people for help if you needed it? Why or why not?
9. List out some ways to help students in crisis situations?
10. What are some of the everyday situations teens experience that cause higher than normal anxiety or stress levels? Why?

Training Week 3

Mental Health and adolescents

Adolescence is a significant period for developing, learning, and sustaining social and emotional habits essential for mental well-being. About10-20% of adolescents globally experience underdiagnosed and undertreated mental health conditions. Some are at higher risks of mental health conditions due to their living conditions, stigma, discrimination, marginalization, or lack of access to adequate support.[140] Mental illness can impact many areas of a teen's life. Adolescents with poor mental health possibly struggle with school and grades, and choice making.[141] Suicide is the second leading cause of death in young people aged 15–24 years, a type of mental illness.[142] Mental health problems in youth often go hand-in-hand with increased risk of drug use, violence, and higher-risk sexual behavior.[143] It is imperative to help adolescents cultivate good mental health because many health behaviors and habits are created in adolescence that will carry over into adult years.[144]

[140] Kessler RC, Angermeyer M, Anthony JC, et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry 2007; 6: 168–76.

[141] U.S. Department of Health and Human Services. Mental health: a report of the Surgeon General. Rockville (MD): HHS; 1999.

[142] 4. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication Arch Gen Psychiatry 200.

[143] Merikangas KR, He JP, Burstein M, Swendsen J, Avenevoli S, Case B, et al. Service utilization for lifetime mental disorders in U.S. adolescents: results of the National Comorbidity Survey-Adolescent Supplement (NCS-A). J Am Academic Child Adolescence Psychiatry 2011; 50:32–45.

[144] American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington (VA): APA; 2013

Mental Illness and the Importance of Family Communication

The development of adolescents strongly depends on their families.[145] Therefore, studies have stressed the importance of family dynamics on adolescents' family function. Communication plays an essential role in every family. [146] Family is the first place where the child learns different manners and develops expectations for their social life. Families involve the emotional, physical, and psychological activities of family members.[147] Among the most leading relationships for socialization are family relationships. Families provide each other with social knowledge that serves to guide their decisions and actions. Families are connected to the mental health and illness experiences of other members of the family. Families support the individuals and help members make sense of their illness experiences.[148]

Seeking Help and Finding Support in the community

The researcher provided each leader with a list of support within the community. The researcher expressed the importance of having a list of trusted counselors, health clinics, shelters that can assist the members. The researcher explained how to find these different resources and told them to add to the ones presented to them. Below is the list emailed to the leaders.

[145] Diamond G., Siqueland L, Diamond GM. Attachment-based family therapy for depressed adolescents: programmatic treatment development. Clin Child Fam Psychol Rev. 2003; 6(2):107–127.

[146] Washington T., Rose T, Colombo G, Hong JS, Coard SI. Family-level factors and African American children's behavioral health outcomes: a systematic review. Child Youth Care Forum. 2015; 44:819–834.

[147] Renzaho A. M., Dau A, Cyril S, Ayala GX. The influence of family functioning on the consumption of unhealthy foods and beverages among 1-to 12-y-old children in Victoria. Aust Nutr. 2014;30(9):1028–1033.

[148] Segrin, C. The routledge handbook of family communication, 512-527; 2nd. New York, NY: Routledge, 2013.

Mental illness Resources

1. Emergency: 911
2. National Domestic Violence Hotline: 1- 800-799-7233
3. National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
4. National Hopeline Network: 1-800-SUICIDE (800-784-2433)
5. Crisis Text Line: Text "DESERVE" TO 741-741
6. Lifeline Crisis Chat (Online live messaging): https://suicidepreventionlifeline.org/chat/
7. Self-Harm Hotline: 1-800-DONT CUT (1-800-366-8288)
8. Essential local and community services: 211, https://www.211.org/
9. Planned Parenthood Hotline: 1-800-230-PLAN (7526)
10. American Association of Poison Control Centers: 1-800-222-1222
11. National Council on Alcoholism & Drug Dependency Hope Line: 1-800-622-2255
12. National Crisis Line - Anorexia and Bulimia: 1-800-233-4357
13. GLBT Hotline: 1-888-843-4564
14. TREVOR Crisis Hotline: 1-866-488-7386
15. AIDS Crisis Line: 1-800-221-7044
16. Veterans Crisis Line: https://www.veteranscrisisline.net
17. TransLifeline: https://www.translifeline.org - 877-565-8860
18. Suicide Prevention Wiki: http://suicideprevention.wikia.com

Finding Support in the Community

The Samaritan Inn (Homeless Shelter) **Number**- (972) 542-5302 **Address**- 1514 N McDonald St, McKinney, TX 75071 **Time**- 9am- 6pm **Website**- www.saminn.org	Frisco Family Services Food Pantry **Number**- (972) 335-9495 **Address**- 9085 Dogwood St, Frisco, TX 75033 **Time**- 9am- 5pm	Feeding Texas **Number**- (512) 527-3613 **Address**- 1524 South IH-35, Ste. 342 Austin, TX 78704 **Website**- www.feedingtexas.org
Frisco Family Services - Food Pantry & Emergency Funds **Number**- (972) 335-9495 **Address**- 8780 Third St, Frisco, TX 75034 **Website**- https://www.texvet.org/resources/frisco-family-services-food-pantry-emergency-funds	Texas Health and Human Services **Number**- (877) 543-7669 or (800) 647-6558 **Address**- 149024 Austin, TX 78714-9024 **Website**- www.yourtexasbenefits.com	Local- Collin County Indigent Health **Number** – 972-548-4702 **Address**- 825 N. McDonald Street, Suite 110 McKinney, Texas 75069 **Time**- Monday–Thursday, 8am–4pm **Website**- www.collincountytx.gov
Texas Medicaid **Number** – 1-800-252-8263 **Email Address**- medicaid@hhsc.state.tx.us **Website**- www.benefits.gov/benefit/1640	Local- Haven Behavioral Hospital **Number** – (972) 476-1705; 469-535-6785- 24/7 **Address**- 5680 Frisco Square Boulevard Frisco, TX 75034 **Website**- www.havenfrisco.com	Riverwalk Ranch – Substance Abuse **Number** – (877) 863-3869 **Address**- 6960 Dick Price Rd, Mansfield, TX 76063 **Website**- www.riverwalkranch.com
Frisco Mental Health Services **Number** – 214-551-7407 **Address**- 255 W Lebanon Road, Suite 224 Frisco, TX 75036 **Email Address**- info@friscomentalclinic.com **Website**- www.friscomentalcare.com	Menninger – Mental Health Services **Number** – (713) 275-5400 **Address**- 12301 Main Street Houston, TX 77035 **Time**- Weekdays from 7 am – 8:30 pm & weekends from 8:30 am to 5 pm **Email Address**- CareCoordination@menninger.edu **Website**- www.menningerclinic.org	National Alliance on Mental Illness **Number** – 703-524-7600 **Address**- 4301 Wilson Blvd., Suite 300 Arlington, VA 22203 **Website**- www.nami.org
Passionately Ever After Counseling Center **Number** – (214) 534-6166 **Address**- 812 Lamp Post Ln, Argyle, TX 76226 **Time**- Monday to Wednesday: 8:00AM - 9:00PM Thursday: 8:00AM - 5:00PM	Santé Center for Healing **Number** – 866.625.2279 **Address**- 914 Country Club Rd. Argyle, TX 76226 **Website**- www.santecenter.com	Life Talk Resource Center **Number** – TEXT or CALL: 214-618-9352 **Address**- 8380 Warren Pkwy Suite 204, Frisco, TX 75035 **Website**- www.lifetalkprc.org
Hope Women's Center **Number** – 972-562-4673 **Time**- Monday - Thursday 9:30-4 Friday - Sunday Closed **Address**- 2740 Virginia Parkway Suite 200 McKinney, TX 75071 **Website**- www.myhope.org	Comfort Care Hospice **Number** – 214-385-4786 **Address**- 5200 Paige Rd. Ste. 500 The Colony, Texas 75056 **Time**- Available 24/7 **Email Address**- info@comfortcarehospice.us	Mosaic Family Services **Number** – (214) 821-5393 **Address**- 12225 Greenville Avenue Suite 800 Dallas, TX 75243 **Website**- www.mosaicservices.org

Mental Health and the church

The church owes the body of Christ the responsibility to serve those with various illnesses. One of the mandates Jesus Christ gave the church was to heal the sick. Infections are not just physical but also emotional, as we have learned. One of the primary ways a church can tremendously help those battling illnesses is to create awareness and foster a safe channel for the various individuals. The church should have compassion and walk along the path Jesus did. Within the Christian community, there is a heavy stigma against pursuing therapy for mental

health. There is a lack of availability for professional care in response to mental illness in the church today. Many churches provide small group leaders and pastors but do not equip and train them to deal with severe conditions. Three popular misconceptions in the church for mental illness, such as depression and anxiety, are that the individual has not surrendered their illness to the Lord. God is testing their faith, and they need to spend more time praying and studying the word. Finally, mental illness is proof that they do not have a relationship with God, the more they pray and focus on God, it'll go away. [149]

The participants will then watch a video lesson about dealing with mental health- YouTube Video- Dealing with Mental Health Issues as a Christian. After the video, the group will discuss further. [150]

Pastors also go through their fair share of mental illnesses. Ed Stetzer, who is the executive director of the Billy Graham Center at Wheaton College in Illinois, said, "Many pastors hide their mental illness because they fear their congregations won't listen to someone who is struggling." Sermons and conversations about mental illnesses break the stigma. A youth pastor committed suicide before his death; he posted this: "Loving Jesus doesn't always cure suicidal thoughts," Wilson wrote. "Loving Jesus doesn't always cure depression. Loving Jesus doesn't always cure PTSD. Loving Jesus doesn't always cure anxiety. But that doesn't mean Jesus doesn't offer us companionship and comfort. He ALWAYS does that."[151] As leaders,

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[149] Diaczynsky, L. (2021, May 7). *Mental health and the Church: Student Activities Blog: Liberty University*. Student Activities. Retrieved October 3, 2021, from https://www.liberty.edu/campusrec/student-activities/blog/mental-health-and-the-church/.

[150] ERLC. (2014, July 16). Dealing with Mental Health Issues as a Christian [Video]. YouTube. https://www.youtube.com/watch?v=9Bz0VnUw1PI

[151] Branson-Potts, H. (2019, September 12). Another young pastor advocating for mental health dies by suicide. Los Angeles Times. Retrieved October 9, 2021, https://www.latimes.com/california/story/2019-09-12/california-megachurch-pastor-mental-health-suicide

above all, the church must preach Christ. In a world where so much hatred, pain, and fear, the church should be the source of strength and light through the Holy Spirit.

Group sessions- Various Scenarios

The leaders were invited to discuss each scenario in five breakout groups. The goal was to describe what was happening and to comment on possible reactions to the problem. They were also asked to discuss who might help in each situation and how people might access that help. The final section presented the group with various describing a person's experience of a mental health issue among young people.

SCENARIO 1 Theme: Grief, depression

> Peter is 14 and lives at home and goes to the local high school. When he was 11, his mum died suddenly. Now his father is always at work, and his older brothers and sisters run the household. Everyone is expected to pull their weight and be happy. However, Peter says that, even though everyone thinks he is happy, sometimes he goes home, shuts the door to his bedroom, and cries on his bed for hours. He does not know why he gets so sad, but often he feels very, very lonely.

SCENARIO 2 Theme: Attention seeking / acting out

> Tony is 13 and in his second year of high school. He has a disabled younger brother who is always sick and takes up most of his parents' attention. Tony usually is quiet at school and has always done well. He hasn't wanted to make trouble for his parents because there is already enough stress at home. However, a few months ago, Tony took the day off school, and while hanging around the mall, stole a baseball cap. Everyone said what a great cap it was when he wore it to school the next day. Since then, he's been stealing from stores in the area regularly. Often, he gives presents to his brother, his friends, or his mum.

SCENARIO 3 Theme: Anorexia

> Justine is 14. She has breakfast at home but puts most of it in the bin when her mother is out of the room. When Justine gets to school, she trades the lunches her mother gives her for a piece of fruit. If she goes out with friends, she might get a plate of food but most often gives most of it away to other people. On sports days, she never gets changed in front of anyone else. At school, some of the other kids have started to make jokes about how bony she is.

SCENARIO 4 Theme: Acting out / self-mutilating

Melissa is 16. She says her father has always criticized her and never gives her any praise. She feels like a loner at school but admits she often fights with other students and gets angry if anyone hassles her. She has a reputation for being 'strange' and likes to argue the point with just about anybody in a position of authority. She says she wants to look and act differently. She also says: I've started getting a razor and cutting into my arm. I call my friend, and we talk about doing it. She does it too. We talk about how to do it. I know I can control it, though.

SCENARIO 5 Theme: Anxiety

Nick is 15. He comes from a large family of older brothers who are all now at university. He has never done as well at school as his brothers did, and over the last year, his father has been making him bring in his homework after he's finished it, and sometimes there are big fights afterward. Lately, when he goes to do his homework, he feels sick, gets headaches, and sometimes feels dizzy. Last week on the way home, he had to get off the bus because he got so nervous at the thought of going home that he couldn't breathe and thought he was going to throw up

SCENARIO 6 Theme: Depression/suicide

Kate is 19, has left home, and is looking for a job. Lately, she has been finding it very hard to sleep at night and then get out of bed the following day. She has not had a job interview for a long time and has difficulty paying her bills. Her friends have noticed that she doesn't want to come out with them anymore. She has been going to different doctors to get sleeping pills to help her sleep at night. She now has a drawer full of different types of prescription drugs. She's been talking a lot about how hopeless things are and that things are never going to change for her.

SCENARIO 7 Theme: Relationship loss / acting out

Michael is 22 and works with the biggest steel company in town. He started going out with a girlfriend and thought things were going well. He asked her to marry him. However, she said she wasn't ready for a commitment, and instead, she went overseas on her own. Since then, he can't stop thinking about her and how hurt he feels. He has not been able to sleep and drinks every night. His coworkers started to hassle him a bit about 'not being on the job,' and last week, when the manager yelled at him about something, he started screaming back and almost threw a punch. He has been told to take some time off.

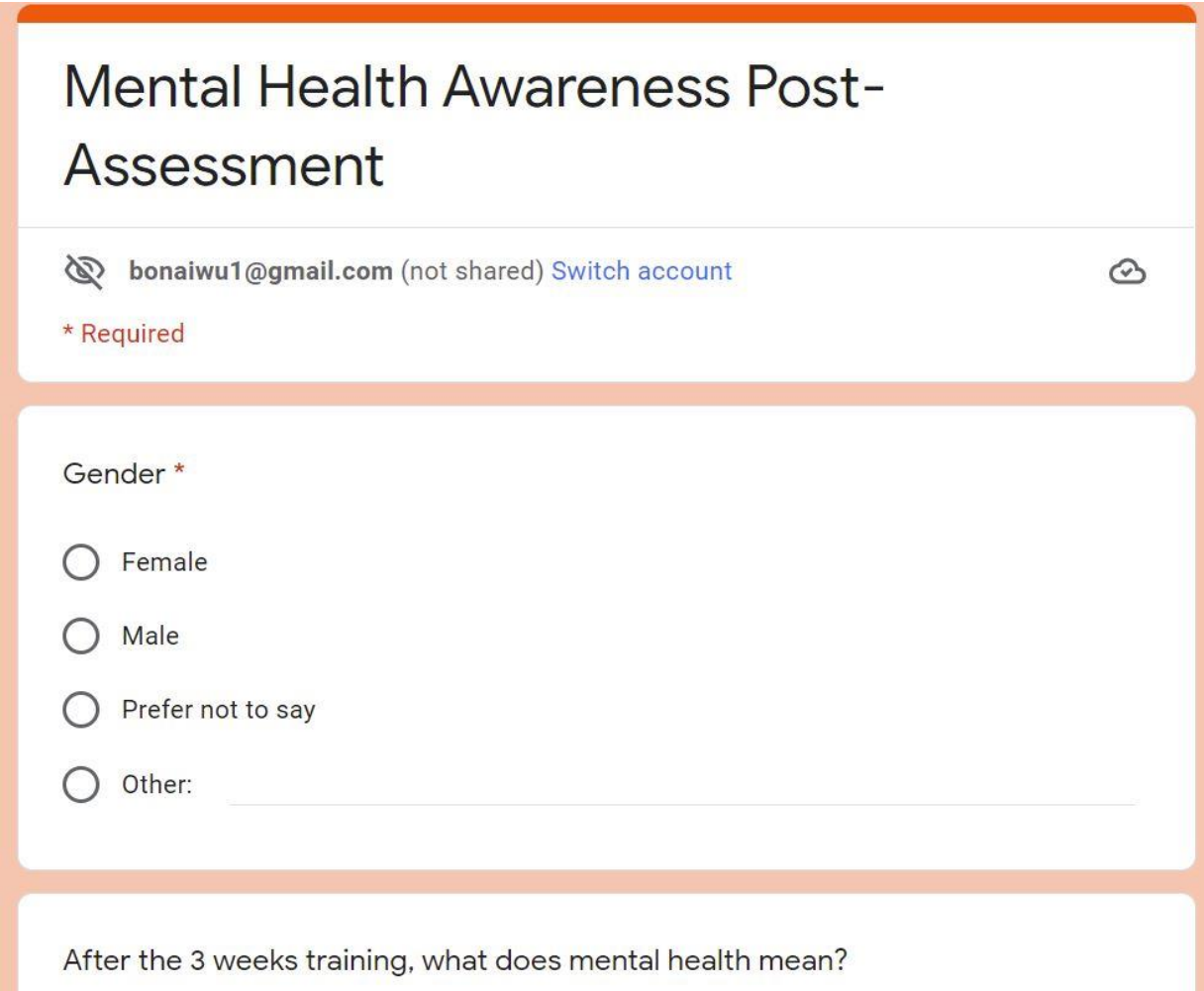
SCENARIO 8 Theme: Early psychotic symptoms

Nigel is 20. He is in his second year at university and has found being there a real struggle. He has trouble sleeping and feels very negative about people and life in general. A few weeks ago, he began having some strange experiences. For example, he started seeing people out of the corner of his eye who were looking straight at him but who were not there when he looked again. He was also sure someone was yelling at him and calling

his name loudly in his ear. It seemed like everyone on TV or radio talked directly to him and told him what to think or do.

These scenarios were directly downloaded from the department of health website.[152]

The training concluded with a post-assessment with six questions on google questionnaire, as



shown below.

Training Week 4

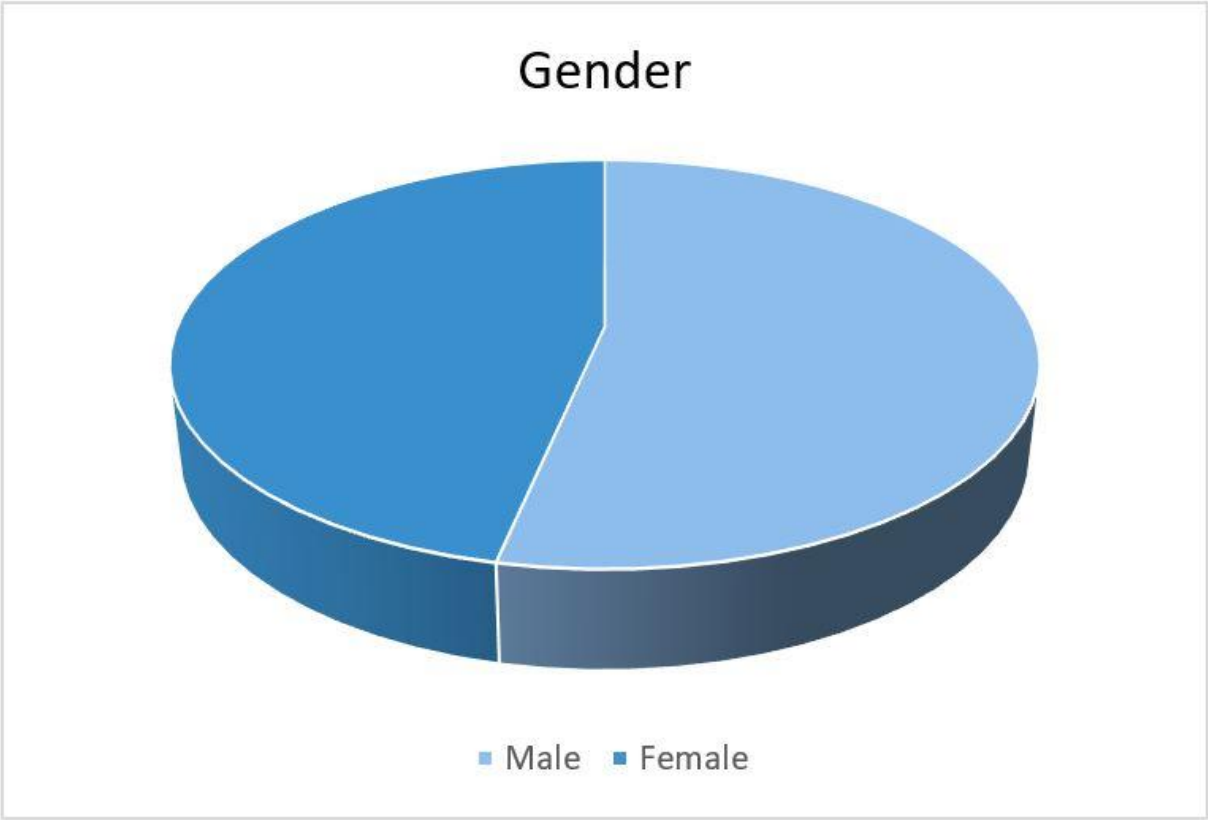
The focus of week 4's meeting was to discuss the complete training with the leaders and give them a chance to express their thoughts. The researcher asked questions such as, what would you like to see in future training and what they learned during the training if they thought

[152] Department of Health | 2.3.3 Responses to scenarios depicting various mental health problems or illness. (1997). The Department of Health. Retrieved October 10, 2021.

it would benefit the church. The leaders' response was positive towards the training; 13 complained that the 3-hour secessions were too short while two felt it was just right.

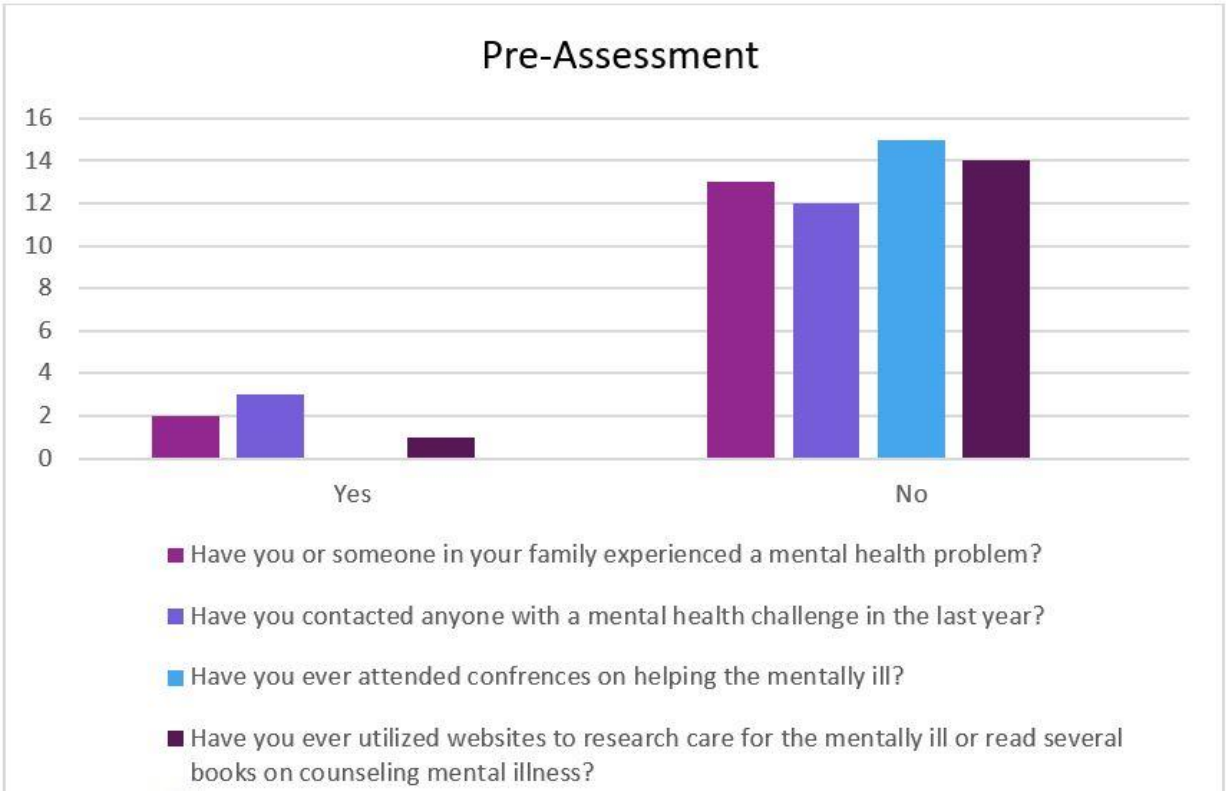
Pre-assessment and post-assessment results

Before the final meeting, the researcher analyzed the pre-assessment and post-assessment taken by the leaders. The researcher's hypothesis was proven correct. The post-assessment shows rapid growth from the pre-assessment. The leaders participating in the training consisted of 8 males and seven females. These 15 leaders represent half of the leadership presently serving in ASIM.

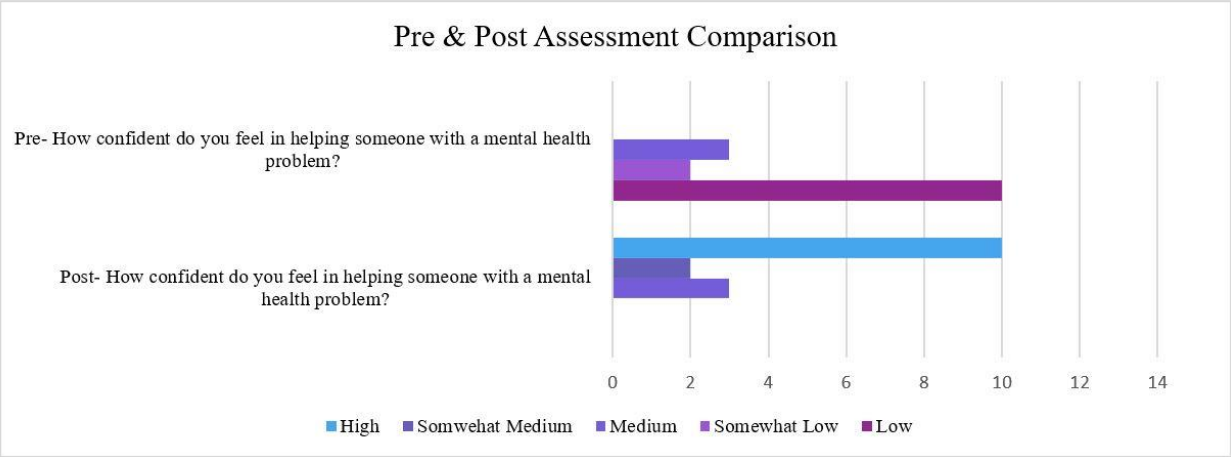


The pre-assessment research questions (4) Have you experienced a mental health problem, or has someone in your family expressed one? (6) Have you contacted anyone with a mental health challenge in the last year? (7) Have you attended conferences on helping the

mentally ill? (9) Have you utilized websites to research care for the mentally ill or read several books on counseling mental illness? Here are the results below.



The first question of the pre-and post-assessment asked what does mental health mean to you? On the pre-assessment, ten leaders left it blank, three said they did not know, and 2 gave a basic answer. On the pre-assessment, all 15 of the leaders were able to describe mental illness accurately. One of the pre-and post-assessment questions asked was how confident you feel in helping someone with a mental health problem. Initially, the majority said low; after the training, the majority chose high, clearly indicating growth.



Finally, the researcher asked the leaders if the church would benefit from having a counseling center open to the church community. All 15 leaders said yes, it would be very crucial. The researcher asked them for ideas on how the church could move forward with this suggestion during the meeting. Below are some of the suggestions:

1. Offering a program to the parents
2. Having mandatory training for the teenagers
3. Setting a permanent class monthly open to the church
4. Hiring a licensed psychologist to serve in the church
5. Incorporating these lessons during the yearly leadership training
6. Training the pastors in the church
7. Preaching mental health awareness from the altar

Conclusion

Chapter four examines the results of the fifteen participants who participated in the research survey and training of the fifteen leaders in Arise and Shine International Ministries. Data collection started from the first to the seventh weeks of the program. The analysis results show a favorable overall increase, proving that mental health awareness training eliminates

stigmas. This highlights the importance of incorporating mental health awareness within the church. The research study revealed that participants understood their role of standing in the gap to those struggling with various illnesses.

Future research should further address stigma coping strategies and treatment of mental illness within the church. Future research should also bridge faith-based communities and the counseling profession, eliminating the stigma connected to professional counseling. This research reveals the need for more assimilation of mental health knowledge in the formal educational training of pastors. The training would be incorporated through Bible colleges, divinity schools' programs, and various partnerships in the community. Research about mental health awareness is growing every day, with solid evidence proving the need for church-based health programs.

CHAPTER 5: CONCLUSION

The primary purpose of this DMIN research was to enlighten ASIM leaders about mental health. The research consisted of two parts; the survey with 15 teenagers who volunteered; based on the findings from the survey, the researcher offered mental health training to 15 leaders presently serving in ASIM. The 3-week training was held for 3 hours via Zoom. The researcher addressed the problem presented, ASIM teenagers struggling with mental health are not receiving adequate counseling or support due to cultural stigma or lack of awareness. The researcher then analyzed the findings and presented them to the leaders during the training. This chapter will highlight further research recommendations and how they will contribute to the growth and development of the church's teenager's mental health.

As stated earlier, mental illnesses can affect anyone, teenagers, adults, or children. People struggling with their mental health may be in close families, live next door, teachers, pastors, etc. However, only half of those affected receive treatment due to the stigma attached to mental health. Any untreated illness does not disappear after a while; the symptoms increase and possibly worsen. For example, a person with a broken bone would need to see a doctor instantly; and a person with severe headaches would need to take medication to seek relief. This concept also applies to individuals struggling with mental illness. Like any part of the body, the brain of a human is subject to diseases, trauma, and chemical imbalances. When the mind suffers, it is necessary to seek help from God, the church, and medical and mental health professionals.

Untreated mental illness can contribute to higher medical expenses, poorer performance at school or work, fewer employment opportunities, increased risk of suicide, and much more. One of the main reasons societies do not accept mental illness is a lack of awareness.

Although the perception of mental illness has enhanced over the past decades for various reasons, studies still show that the stigma against mental illness is not gone. As stated in the research, stigma is dangerous because it affects the person seeking treatment and limits the number of resources available for proper treatment. This research proves that training and awareness about mental illness can drastically change an individual's view. Hosea 4:6 states that people are destroyed or perish for lack of knowledge. Also, Psalm 119:130 states, "the entrance of Your words gives light; It gives understanding to the simple." Based on the 3-week training conducted with ASIM leaders, the researcher concluded that if this specific training were to occur in churches globally, a drastic view of mental illness could occur. This change could potentially eliminate stigma in multiple communities, churches, homes, and families.

After the research training, the researcher found that ASIM's lack of mental illness awareness was not entirely due to stigma; it was due to lack of knowledge and unfamiliarity about mental illness. A study showed that church leaders believe that mental disorders derive from biological and genetic factors. Other leaders perceive mental conditions such as depression, anxiety, and schizophrenia as originating from psychosocial or spiritual matters.[153] When the opportunity arose for ASIM leaders to learn, they accepted it with an open mind. After the training, the leaders personally requested the researcher to plan a training for the entire church leaders. When presented with facts and analysis, the leaders were able to see that indeed there was a problem, and the problem must be fixed.

As denoted in chapter two, faith community leaders are first responders when individuals and families face mental health problems. A trained leader can help dismiss misunderstandings and reduce the stigma associated with mental illness, treatment, and prayers. Many people who

[153] Payne, J. (2009). Variations in pastors' perceptions of the etiology of depression by race and religious affiliation. Community Mental Health Journal, 45(5), 355-365.

struggle with mental illness do not want to talk about it. Constant communication about mental illness educates people to help them realize how common it is. Science is highly developed today; there is a vast amount of knowledge about the human brain and treatments to help manage mental illnesses successfully.

Recommendations for Church Leaders

Action Step 1

A recommendation to all pastors, lay leaders, elders, deacons, and group leaders would emphasize three main points. First, the church should understand that church leaders are official leaders of religious congregations, and their fundamental responsibility is to offer spiritual development and care to the parishioners. Leaders come across individuals with mental health conditions frequently which requires several approaches. The leaders need to see the person rather than the illness first and realize that ignoring it does not make it disappear. The church should generate a more welcoming environment to assist individuals and families facing a mental health crisis. It is imperative that faith leaders model openness keeping in mind that the congregation observes and follows their lead. Demonstrating a welcoming attitude enables the congregation to nurture mental, physical, and spiritual well-being towards those in need and allows them to seek help for themselves if needed. Matthew 12:14-16 explains, love in action is rejoicing with those rejoicing, mourning with those who mourn, and living in harmony with one another. A leader should meet with the individual and family to evaluate their needs and problems, indicating love.

Action Step 2

The second recommendation for the leaders within the church is to educate and train the leaders with the church. The leaders are in the best position to educate the congregation and the

leaders about mental health to overcome the stigma and shame associated. To be a leader, worker, or serve in ASIM, they must undergo “Workers Training.” This training takes place in the church for three weeks and is concluded with an evaluation. The researcher’s recommendation to ASIM includes a mental illness segment in the Workers' training. The church should also offer regular classes open to the church community, understanding and accepting. The church should also consider hiring a psychologist who can work personally with the church and the members. Because of their lack of familiarity with mental illness, many pastors fail to see the real problem and offer essential encouragement from Scripture. Therapists and psychologists can be particularly beneficial in recognizing the exact illness and putting them on the proper recovery track. They are trained to help with these specific problems without judgment.

Action Step 3

The final recommendation for the leaders within the church is to include mental health awareness in sermons or discussions from the pulpit. Having a panel discussion, taking questionnaires regarding this will normalize mental health. Another easy way to include mental health in the church is to pray for people living with mental illness and their families during the week. The church could invite people living with mental illness to share their testimony in a church service. Encourage every member to physically care for the sick and take a meal to them. The leaders can give the congregation a survey that asks them questions related to mental health. The church can provide a referral list of mental health resources available within the community. Another way to include mental illness discussions and awareness within the church is to create a space for free NAMI (National Alliance on Mental Illness) support groups to meet at the church.

Mental Health Awareness Sunday

One of the ways to implement mental health awareness in the church is to preach it from the pulpit. This awareness Sunday can be held monthly, quarterly, or once a year in May, Mental Health Awareness Month. Sixty-five years ago, Mental Health America designated May as Mental Health Month. This month's goal is to raise awareness about mental illnesses in communities and social media and stress the importance of mental wellness for all. Mental Health Sunday can be a way for congregations to erase the stigma surrounding mental illness.[154] The church should realize that they are following the example of Jesus by welcoming and supporting members with mental health challenges. First, during the awareness Sunday, the church should stress and remind the congregation that God is never far from them; they ARE God's offspring, child, and His beloved. The church should use affirmative words in line with the scriptures.

Second, the church should present important facts about mental illness and stigma. According to a study overseen by Harvard Medical School, 26% of adults in the United States have anxiety, mood, impulse control, or substance disorder in a particular year. This fact means one in five adults in the United States struggle with mental illness. 22% of those disorders were categorized as severe, 37% mild, and 40% minor.[155] The pastor could use an illustration and have one in every five people in the room stand up. Every person standing represents a degree of a mental health problem or disorders a particular person has in a year, with severs, mild or minor.

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[154] Bruce ML, Smith W, Miranda J, Hoagwood K, Wells KB. Community-based interventions. *Ment Health Serv Res.* 2002;4(4):205–214.

[155] Kessler R, White LA, Birnbaum H, Qiu Y, Kidolezi Y, Mallett D, Swindle R. Comparative and interactive effects of depression relative to other health problems on work performance in the workforce of a large employer. *J Occup Environ Med.* 2008;50(7):809–816.

Explain that if they are not standing, someone they know or love could be the one among the five.

Third, personalize the service, bring it closer to home. An important question to ask and explain would be, "How many families in the church have a loved one who battles with a serious, acute, or persistent mental health issue?" Based on statistics, whether the church admits it or not, one in five of the congregation present is silently struggling.[156] Ask the church family to look around; everyone looks well dressed and all smiles, but someone is most likely hurting, and they're afraid to tell speak out.

Fourth, have a person who has battled mental illness share their testimony. Revelations 12:11 says, "they overcame, conquered, and defeated him by the blood of the Lamb and by the word of their testimony" (NKJV). Here is an example in a church's Mental Health Awareness Sunday of a leader who suffered from intense postpartum depression:

> "The church's religious education coordinator, ordinarily shy and soft-spoken, told about her years-long struggle with anorexia and her subsequent involuntary admission to a locked psychiatric ward where no pens, drawstrings, or diet coke were allowed. "If you ever want to hit the dirt-floor bottom of your soul," she said, "try ending up somewhere where it's considered risky to have a ballpoint pen." The congregation was spellbound as she talked. Perhaps, part of the reason her testimony was so powerful is that this person had been raised in a stable Protestant home. "She could easily be one of our kids," one listener said.[157]

The power of a testimony allows the congregation to relate and grow from it. Then, encourage the church to get medical help for mental health matters. Praying harder will not fix

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[156] Bell RA, Franks P, Duberstein PR, Epstein RM, Feldman MD, Garcia EF, Kravitz RL. Suffering in silence: reasons for not disclosing depression in primary care. Ann Fam Med. 2011;9(5):439–446.

[157] Cooper LA, Brown C, Vu HT, Ford DE, Powe NR. How important is intrinsic spirituality in depression care? A comparison of white and African American primary care patients. *J Gen Intern Med.* 2001;16(9):634–638.

the illness. Finally, remind the church that God's love is not far from them, no matter what they are going through.

The Mental & Emotional Health of Pastors

There is a unique story by a well-known Rabbi, which focuses on the need for every individual, no matter their position to seek mental wellness. "A man went to see his physician because he wasn't feeling well. "Doctor," he said, "I am suffering from a dark and unshakable depression. Nothing I do gives me any relief. I am overwhelmed with pain, and most days, I can't even make it out of bed. Doctor, what should I do?" The doctor thought for a moment then offered the following treatment plan. "This is what you need to do. Tonight, go to the theatre where the Great Carlini is performing. He is the funniest man globally, and everybody who sees him finds him hysterical. By all means, go see Carlini. He is guaranteed to make you laugh and drive away your depression." Upon hearing these words, the man burst into tears and sobbed uncontrollably. "But doctor," he said, "I am Carlini."[158] At times, people are troubled but have no one to whom they can unburden themselves, including spiritual leaders.

As stated earlier, mental illness can happen to anyone. The importance of creating awareness about it enables any person to seek help. This portion is specifically for the leaders and pastors within ASIM. The church has over 30 active leaders holding key positions within the church. According to statistics, one in five struggle with mental illness. Creating an open conversation about this can be the healing somebody desperately needs. Mental illness is not an easy topic for anyone to discuss, but it is vital to discuss it with open eyes and heart. In ministry, the primary job of a pastor or a leader is typically designed to help and assist others. A pastor will walk with families through grief, celebrate with families, counsel, and pray for those

[158] National Alliance on Mental illness.

struggling. A pastor constantly and continuously pours into others for the benefit of Christ. It does not mean they cannot suffer from mental illnesses; they are also human beings.

COVID-19 has drastically altered the lives of many individuals globally, including pastors. In a study conducted during the pandemic with 400 pastors, clergy members revealed that they were worried about finances, technological challenges, offering pastoral care, and the members' lack of access to technology. They experienced a tremendous feeling of stress and irritation.[159] Stress and burnout have been discovered to negatively affect an individual's physiological health, including intensified blood pressure, cholesterol levels, and risk of heart disease.[160] These findings indicate that pastors and leaders are experiencing increased stress levels that will put them at heightened risk for developing a mental illness. As they take care of others, pastors need to recognize that if they do not care for their mental health, they will not have the emotional and mental ability to serve anyone else adequately.

Pastoral mental health is a topic that has infrequently been researched, yet a pastor's mental health can considerably impact churches, communities, and even nations.[161] Pastors encounter leadership and spirituality issues as anyone else. Research has shown that the average pastor works between fifty and sixty hours per week, spends inadequate time in personal spiritual development, and often lacks a close intimate friend or support-accountability network.[162] They

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[159] Earls, "Most Churches Have Stopped."

[160] Swenson, R. A. (2002). Margin: The overload syndrome: Learning to live within your limits. Colorado Springs: CO.

[161] Royal KD, Thompson JM. Measuring Protestant Christians' willingness to seek professional psychological help for mental illness: A Rasch measurement analysis. *Journal of Psychology and Christianity*. 2012;31(3):195–204.

[162] Jinkins, M., & Wulff, K. (2002, May). Austin Presbyterian Theological Seminary's clergy burnout survey. Congregations (Publication of the Alban Institute). Retrieved on December 26, 2008.

often tend to disregard and ignore their personal spiritual growth as they nurture their flock. These extended hours and dedication lead to burnout.

Burnout has been characterized as a complicated "psychological syndrome." It occurs due to; emotional exhaustion, depersonalization, and reduced personal accomplishment.[163] When this happens to a leader, it is possible to become distant, emotionally decompress and have difficulty functioning normally. A pastor is prone to overwork, but focusing on their mental health is vital. A study about the impact of pastors' spiritual burnout proves that pastoral leaders undergo added stress, frustration, loneliness, isolation, and spiritual dryness due to burnout. The study reached this conclusion by interviewing eight church leaders using an open-ended structure. Their ages ranged from 41-62, and they have served within the ministry for 4 to 51 years. The congregational size for all eight pastors varies from 18 to 750 people. One of the pastors shared a relatable story that a plethora of leaders experiences daily.[164]

> A second pastor, Peter, provided an equally detailed description of his spiritual practices and burnout experience. Unlike Sean, who identified his inability to say "no" to all that was asked of him, Peter identified unresolved personal issues and unresolved conflict with church members as the primary cause of burnout. "One of the biggest things comes from within," he stated. "It's the threat of rejection that over time, they [church members] will decide they don't really like you. It comes from a need to be loved, appreciated, and successful." Peter further defined his burnout experience as "a loss of vision for ministry due to unresolved conflicts that have hindered me to the point of dysfunction." Through vivid metaphor, he described his burnout experience. "Burnout is when your filters are completely clogged, and there's a lot of putting out and not a cleaning out." He added, "All burnout is spiritual dysfunction. You are trying to be superman."
>
> After his dad, a former pastor died, Peter described the worst burnout incident of his life. "That was depression," he said. "A real clinical depression…. I could always call my dad up, and he would listen to me and help me through it. I wasn't co-dependent on my father. But it [his death] happened suddenly, and then it was all on me. I was the one that

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[163] Maslach, C., & Jackson, S. E. (1986). Maslach Burnout Inventory manual (2nd ed.). Palo Alto, CA: Consulting Psychologists Press.

[164] Chandler, D. J. (2010). The Impact of Pastors' Spiritual Practices on Burnout. *Journal of Pastoral Care & Counseling*, *64*(2), 1–9.

> was supposed to fix everything." The loss of his father, who had become his primary support system, created a new challenge of taking care of his aging mother. Fortunately, he found support in another older pastor whom he frequently consulted for pastoral advice and personal feedback. His situation changed when he enrolled in a doctoral program. "Seminary was renewing, and I was getting input as to what to do." In addition, he participated in a pastor restoration process to allow for personal healing and to address burnout. He is now the senior pastor of a church he founded six years ago. He submitted that his restoration process, within the context of a minor, supportive group, was strategic to identifying and resolving unhealthy behavioral patterns and unresolved church issues. The accountability and relational care provided a safe context for personal growth.[165]

The findings of this research study indicate that pastors are prone to an overextended workload. This result confirms that no matter what age or how many years of experience a leader has, they can also battle mental illness.[166] With this knowledge in mind, the church needs to create a system. The church should develop preventive measures to effectively manage burnouts and generate healthy, durable, and renewed leaders. Establishing a solid awareness of mental health will benefit the teenagers, the church's leaders, and members in the long run.

Similar Study

The result of the research project is in line with some of the other research which has been analyzed. For example, research was conducted to discover if training provided to clergy impacted their knowledge of mental disorders, opinion regarding helpful resources, self-confidence to help individuals experiencing a possible mental health crisis, and willingness to refer out to supportive resources in the care of congregants. The participants were given two different imaginary cases of mental illness. They were then given a pre-assessment to answer 45 survey questions about the two separate cases revealing how they would handle the mental health problem. After the training, they were asked to answer the same 45 questions about two different

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[165] Chandler, D. J. (2010). The Impact of Pastors' Spiritual Practices on Burnout. *Journal of Pastoral Care & Counseling*, *64*(2), 1–9.

[166] Ibid., 3-5.

issues. The results proved that more participants were self-confident about assisting an individual going through a mental illness such as depression after the training.[167]

The second similar study concluded that, for church leaders to be equipped to meet the mental health needs of individuals and families, they must be trained. The study also mentioned additional training about the appropriate hospitality in the church towards people with mental illness. The study emphasizes that the church should begin with the beliefs and perspectives they currently have; they might hinder or facilitate hospitality towards people with mental illness unknowingly.

One important unifying theme within the Christian community is belonging. Rather than only involving people with mental illness, nurturing a sense of belonging is even more critical to guarantee that people with mental illness are not ostracized.[168] The researcher of this study used eight various ministries with different denominations. The goal was to have church-based focus groups where people with mental illness would be included. The church members from each of the eight parishioners were invited to a 90–120 minutes focus group. Various questions were asked, such as:

1. When you hear "mental illness," what first comes to mind?
2. When you hear "mental health," what comes to mind?
3. Do you distinguish between mental illness and mental health? Why or why not?
4. How would you define compassion towards people with mental illness?
5. How would you define hospitality towards people with mental illness?

[167] Patino, C. M., & Ferreira, J. C. (2018). Inclusion and exclusion criteria in research studies: definitions and why they matter. Journal Brasileiro de Pneumologia, 44(2), 84-84.

[168] Bishop, R. K. B. (2018). A new church model: Inviting and including people with or affected by mental health conditions [Doctoral dissertation, Asbury Theological Seminary]. Asbury Theological Seminary ePlace.

6. Do you know people with mental illness who come to your church? What kinds of problems do they have?
7. When someone has a mental illness and comes to your church, what do you think their experience is?
8. Do you think it is important to address mental health in the church, and why?
9. In what ways does your church address mental health?
10. In what ways does your church struggle with addressing mental health?
11. How do you now or in the past personally experience mental illness?
12. What keeps people in your church from getting mental health help? Do you think your church has a role in these challenges?
13. What do you think would be the positives of being more welcoming of people with mental health needs at your church?
14. What do you think would be the drawbacks of being more welcoming of individuals with mental illness at your church?
15. Are there any other ideas from Scripture that aid you in thinking of how the church should help those encountering distress or suffering?

This study also delved into cultural views of mental illness that might help or impede people seeking help with mental illness at each church. The results showed a couple of things, one of the similarities that emerged across all groups was what hospitality intended for the church. Most participants expressed that hospitality meant church members noticed those with mental health needs, recognized them as persons, and portrayed love. Others felt that hospitality

included strong themes of acceptance and a sense of belonging and welcoming a person with open arms, no matter who the person was.[169]

Among all the ethnic and cultural groups represented in the study, stigma was the one hindrance they all faced to receiving genuine hospitality. The study researcher suggested a few actions the church should implement to eliminate stigma, such as continuous mental health training. Some others were medication use, intentional support and guidance for pastoral staff and leaders, leadership training, and spiritual equipping.

The last similar study shows research on how clergy perceive depression. As shown in other studies, many who sought mental disorders first turned to the church and received help from a clergy member. It is also evident that the church is contacted more often than psychiatrists or general medical doctors regarding mental illness. It reveals that individuals seek help from leaders because they are more familiar with clergy, clergy do not charge fees, and less stigma is involved in discussing one's problems with the church.

The author conducted the first part of the survey with 219 pastors in California. The author then completed a 2-hour unstructured interview with the church leaders to discover their perspective of depression as a church leader. After this process, the researcher narrowed them down to 204 pastors. Out of the 204 pastors, 29 were women, and 175 were men; their ages ranged from 20 to over 65 years of age. They have served for 1 to over 40 years in the ministry. 75% of the pastors had no training or education to prepare them for their current position.

In the actual study, pastors were asked demographic questions; what depression meant to them and their views on the causes of depression. The results of this study affirm that mental

[169] Lehmann, C. S., Whitney, W. B., Un, J., Payne, J. S., Simanjuntak, M., Hamilton, S., Worku, T., & Fernandez, N. A. (2021). Hospitality Towards People with Mental Illness in the Church: a Cross-cultural Qualitative Study. *Pastoral psychology*, 1–27.

health first responders must have a vast knowledge about depression, and different societies and cultures respond differently based on their race or denomination.

The study results align with past research asserting that African Americans think differently about mental health issues such as depression. It proves that an African American would cope with depression by using spirituality more often than a Caucasian patient. This research also concludes that an African American patient would utilize the church members for various support measures more often than a Caucasian.[170]

Summary

Most of the leaders within the church are not trained to recognize and detect signs of mental health issues in individuals.[171] Chapter 2 noted several similar studies that researched and trained individuals in mental health, such as MHFAT and Mental Health 101. MHFAT is a skills-based training course that educates participants about mental health and substance-use issues. It is a one-day training for 5 hours. The course teaches recognizing, understanding, and responding to signs of mental illnesses and substance use disorders. The training gives a person the skills needed to reach out and provide initial help and support to someone in need. Mental health 101 is a 3-hour training for one day. The participants will be presented with the most common mental illnesses, the risk factors, signs, and symptoms, and support someone experiencing these. At the end of the training, the participants receive a list of local resources.

This study examined the impact mental illness had on ASIM leaders and their response to the problem presented. Many of the participants who partook in training had no prior knowledge or experience with mental health. Understanding mental health significantly changed their

[170] Payne, J. (2009). Variations in pastors' perceptions of the etiology of depression by race and religious affiliation. Community Mental Health Journal, 45(5), 355-365.

[171] Reavley & Jorm, 2011

response from the pre-to-post survey due to the 3-week training presented. Research demonstrated that though stigma was initially apparent among the leaders, after the training, it disappeared. The leaders' focus became to impact the teenagers going through a mental battle. Finally, the confidence to assist someone experiencing mental health issues increased after the training. As stated, there have been several studies portraying the problems families impacted by mental illness face, such as stigma, lack of resources, information, and support. The more churches and institutions are trained, the less apparent stigma.

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Appendix A

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

July 23, 2021

Blessed Onaiwu
Teresa Duez

Re: IRB Application - IRB-FY20-21-988 Benefits of Mental Illness Training Programs in the Church

Dear Blessed Onaiwu and Teresa Duez,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study does not classify as human subjects research. This means you may begin your project with the data safeguarding methods mentioned in your IRB application.

Decision: No Human Subjects Research

Explanation: Your study is not considered human subjects research for the following reason: Your project will consist of quality improvement activities, which are not "designed to develop or contribute to generalizable knowledge" according to 45 CFR 46. 102(l).

Please note that this decision only applies to your current application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued non-human subjects research status. You may report these changes by completing a modification submission through your Cayuse IRB account.

Also, although you are welcome to use our recruitment and consent templates, you are not required to do so. If you choose to use our documents, please replace the word *research* with the word *project* throughout both documents.

If you have any questions about this determination or need assistance in determining whether possible modifications to your protocol would change your application's status, please email us at irb@liberty.edu.

Sincerely,

G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

Appendix B

Permission to Conduct Research Study

Bishop Nosa Onaiwu
Arise and Shine International Ministries
1001 Airport Freeway, Bedford, TX 76021

RE: Permission to Conduct Research Study

Dear Bishop Nosa Onaiwu,

I am writing to request permission to conduct a research study at Arise and Shine International Ministries. I am currently enrolled in the Doctor of Ministry program at Liberty Christian University and am in the process of writing my thesis project. The study is entitled The Benefits of mental illness training programs in the church.

To perform this study, I would need to recruit 20 teenagers to anonymously complete a mental health questionnaire. Due to the nature of the study, I hope to recruit (the mother, father, or guardian) of these students to partake in a brief meeting about the survey and research process. Interested teenagers, who volunteer to participate, will be given a consent form to be signed by their parent or guardian and returned to the primary researcher at the beginning of the survey process. Parents who volunteer to participate will also be given consent forms to be signed and returned to the primary researcher.

I would also need 20 leaders, including the pastors, the elders, the deacons, the deaconesses, the evangelists, and the head of departments, to participate in a 3-hour training for three consecutive weeks. Before the training, the volunteers would fill out a survey checking their knowledge of mental health. After the training, the volunteers would take a post-survey to measure their growth. The goal is to create mental health awareness within the church and suggest ways to assist those currently battling it.

If approval is granted, student participants will complete the survey in a classroom or other quiet setting within the church. The survey process should take no longer than 45 minutes. Parent participants would complete their meeting before the teenagers. The training will also be held in the church's worship center. The survey results will be pooled for the thesis project, and the individual results of this study will remain absolutely confidential and anonymous. Should this study be published, only pooled results will be documented. No costs will be incurred by either the church or the individual participants.

Your approval to conduct this study will be greatly appreciated. I will follow up with a telephone call next week and be happy to answer any questions or concerns you may have. You may contact me at my email address: [redacted]

If you agree, kindly sign below and return the signed form in the enclosed self-addressed envelope. Alternatively, kindly submit a signed letter of permission on the church's letterhead acknowledging your consent and authorization for me to conduct this survey/study at Arise and Shine International Ministries.

Sincerely,
Blessed Onaiwu

Approved by:

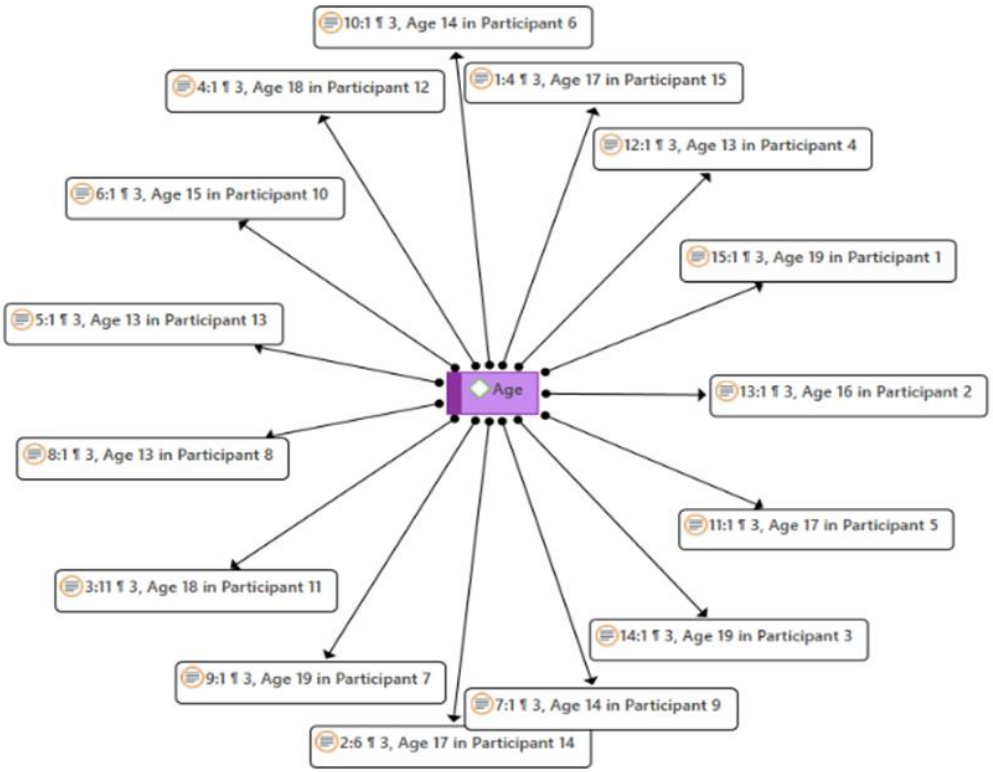
Print your name	Signature	Date
BISHOP NOSA-ONAIWU	[redacted]	09-17-2021

Appendix C

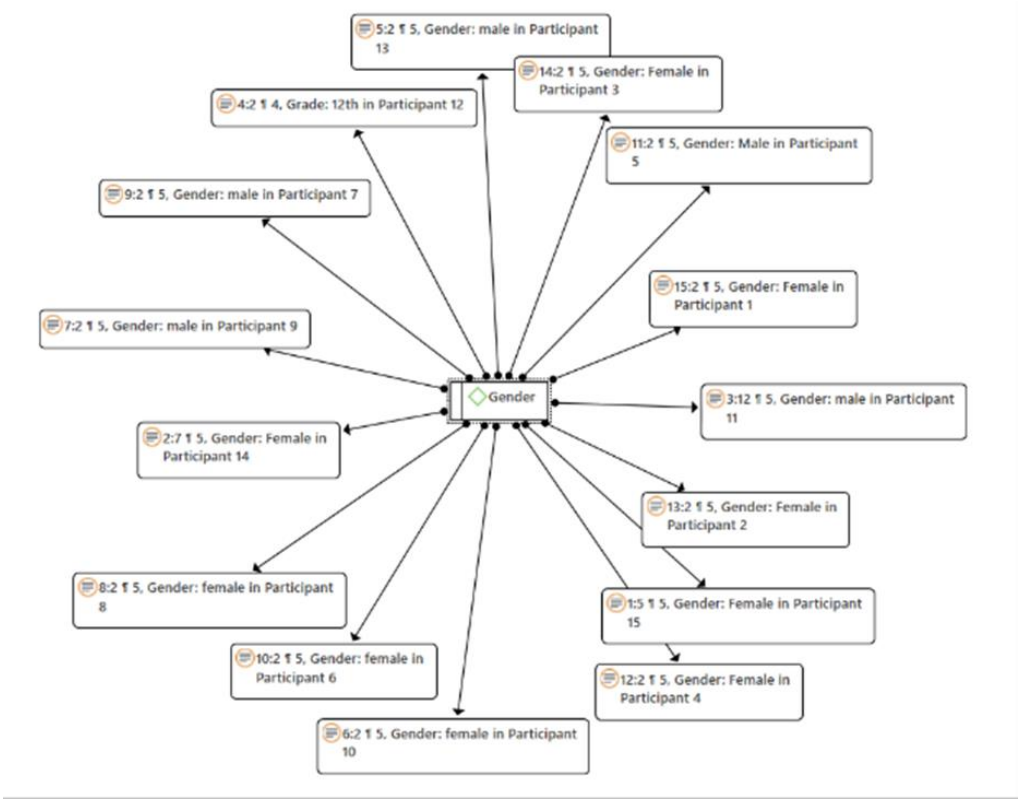
Mental Health Awareness Survey

Number of Participants	Is the parent Present (Yes or no)	Is the participant present (Yes or no)
1.	✓	✓
2.	Yes	Yes
3.	YES	YES
4.	Yes	Yes
5.	✓	✓
6.	Y	Y
7.	Yes	Yes
8.	Quan	Quan
9.	Yes	Yes
10.	Yes	Yes
11.	YES	YES
12.	Yes	Yes
13.	✓	✓
14.	Yes	Yes
15.	Yes	Yes
16.	Y	Y
17.	Yes	Yes
18.	Yes	Yes
19.	Yes	Yes
20.	YES	YES

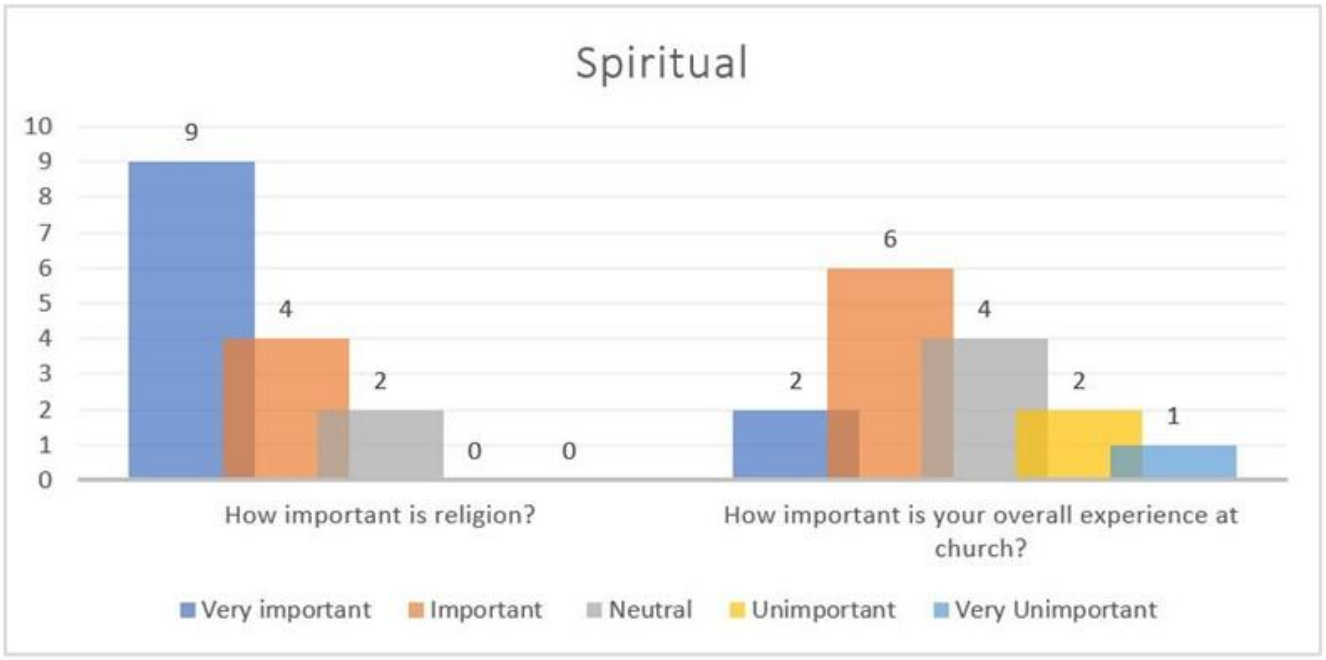
Appendix D


10:1 ¶ 3, Age 14 in Participant 6
4:1 ¶ 3, Age 18 in Participant 12
1:4 ¶ 3, Age 17 in Participant 15
12:1 ¶ 3, Age 13 in Participant 4
6:1 ¶ 3, Age 15 in Participant 10
15:1 ¶ 3, Age 19 in Participant 1
5:1 ¶ 3, Age 13 in Participant 13
Age
13:1 ¶ 3, Age 16 in Participant 2
8:1 ¶ 3, Age 13 in Participant 8
11:1 ¶ 3, Age 17 in Participant 5
3:11 ¶ 3, Age 18 in Participant 11
14:1 ¶ 3, Age 19 in Participant 3
9:1 ¶ 3, Age 19 in Participant 7
7:1 ¶ 3, Age 14 in Participant 9
2:6 ¶ 3, Age 17 in Participant 14

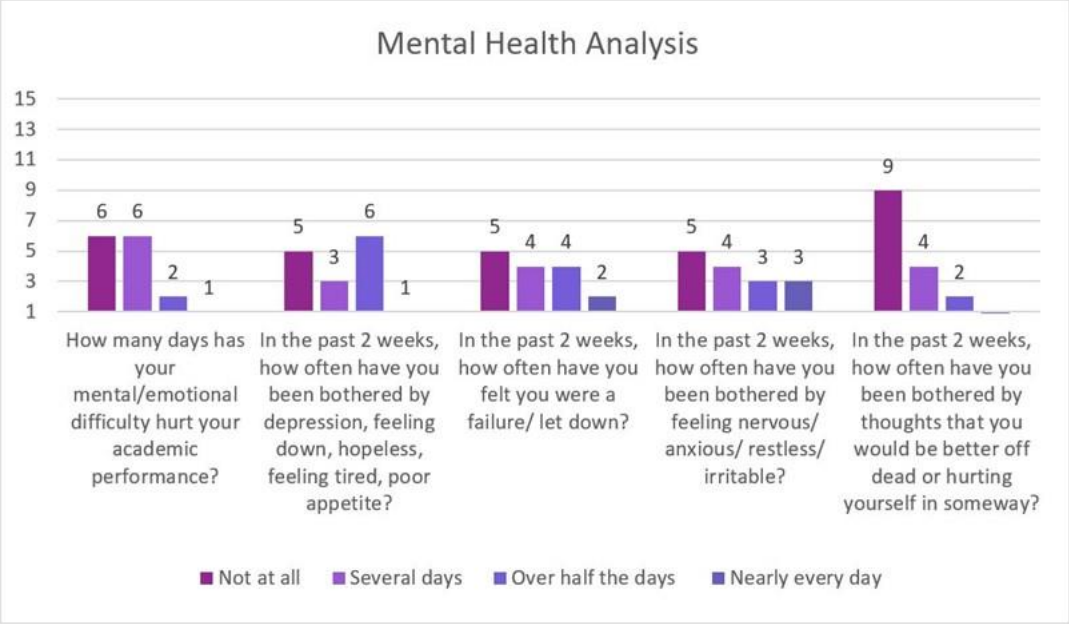
Appendix E


5:2 ¶ 5, Gender: male in Participant 13
14:2 ¶ 5, Gender: Female in Participant 3
4:2 ¶ 4, Grade: 12th in Participant 12
11:2 ¶ 5, Gender: Male in Participant 5
9:2 ¶ 5, Gender: male in Participant 7
15:2 ¶ 5, Gender: Female in Participant 1
7:2 ¶ 5, Gender: male in Participant 9
Gender
3:12 ¶ 5, Gender: male in Participant 11
2:7 ¶ 5, Gender: Female in Participant 14
13:2 ¶ 5, Gender: Female in Participant 2
8:2 ¶ 5, Gender: female in Participant 8
1:5 ¶ 5, Gender: Female in Participant 15
10:2 ¶ 5, Gender: female in Participant 6
12:2 ¶ 5, Gender: Female in Participant 4
6:2 ¶ 5, Gender: female in Participant 10

Appendix F


Spiritual
10
9
8
7
6
5
4
3
2
1
0
9
4
2
0
0
2
6
4
2
1
How important is religion?
How important is your overall experience at church?
Very important
Important
Neutral
Unimportant
Very Unimportant

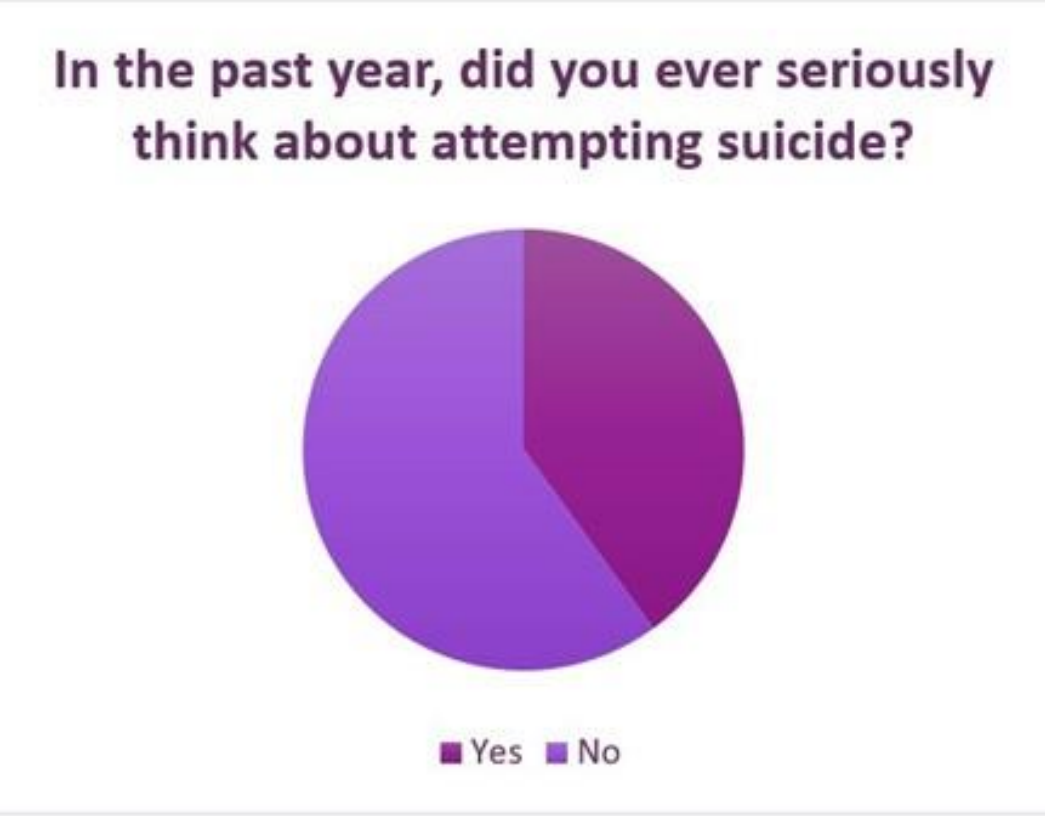
Appendix G


Mental Health Analysis
15
13
11
9
7
5
3
1
6 6 2 1
5 3 6 1
5 4 4 2
5 4 3 3
9 4 2
How many days has your mental/emotional difficulty hurt your academic performance?
In the past 2 weeks, how often have you been bothered by depression, feeling down, hopeless, feeling tired, poor appetite?
In the past 2 weeks, how often have you felt you were a failure/ let down?
In the past 2 weeks, how often have you been bothered by feeling nervous/ anxious/ restless/ irritable?
In the past 2 weeks, how often have you been bothered by thoughts that you would be better off dead or hurting yourself in someway?
Not at all
Several days
Over half the days
Nearly every day

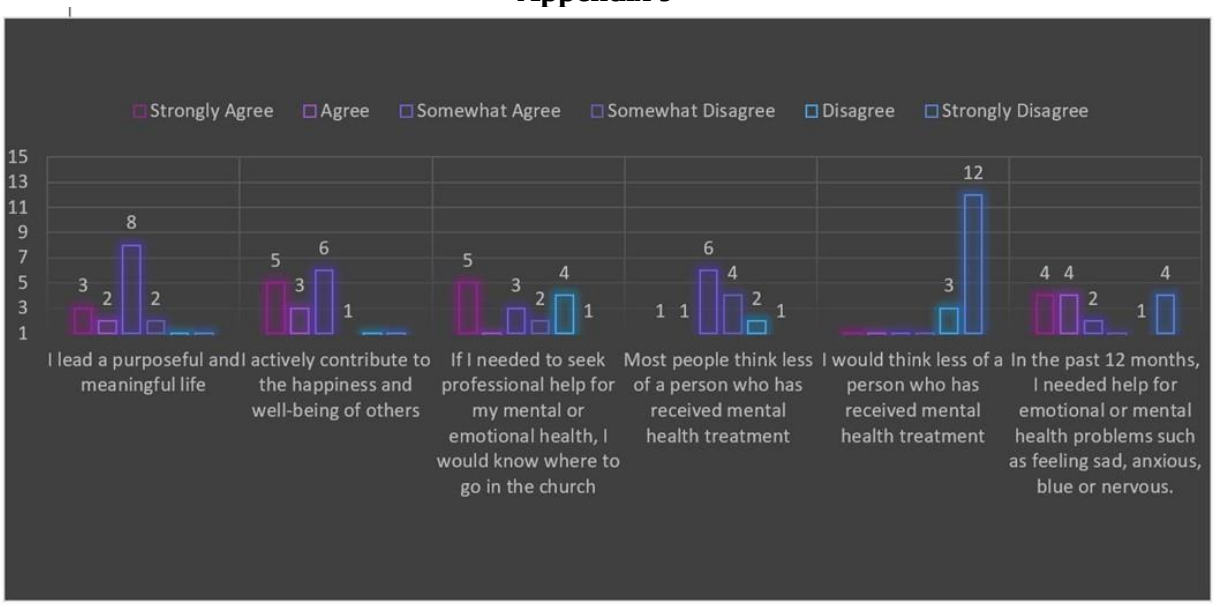
Appendix H


Over the last 2 weeks, have you had difficulty sleeping?
Yes
No

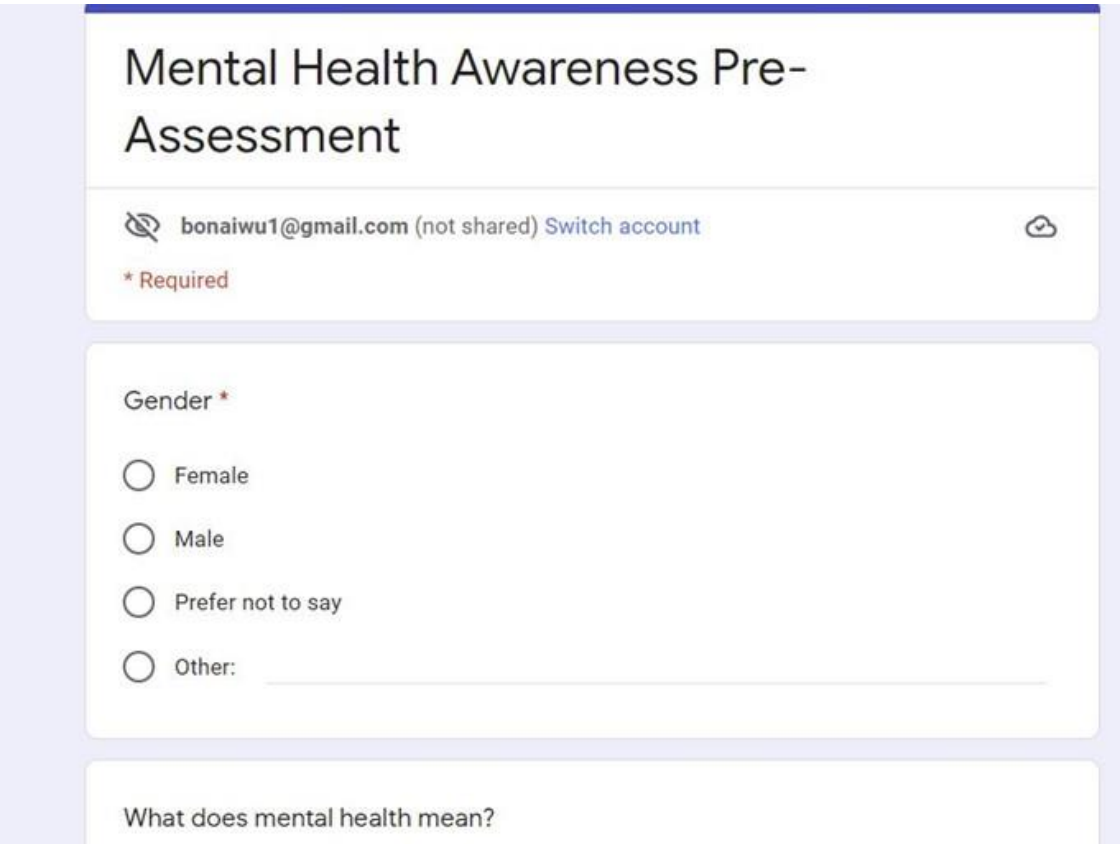
Appendix I


In the past year, did you ever seriously think about attempting suicide?
Yes
No

Appendix J


Strongly Agree
Agree
Somewhat Agree
Somewhat Disagree
Disagree
Strongly Disagree
15
13
11
9
7
5
3
1
3 2 8 2
5 3 6 1
5 3 2 4 1
1 1 6 4 2 1
3 12
4 4 2 1 4
I lead a purposeful and meaningful life
I actively contribute to the happiness and well-being of others
If I needed to seek professional help for my mental or emotional health, I would know where to go in the church
Most people think less of a person who has received mental health treatment
I would think less of a person who has received mental health treatment
In the past 12 months, I needed help for emotional or mental health problems such as feeling sad, anxious, blue or nervous.

Appendix K



Mental Health Awareness Pre-Assessment

bonaiwu1@gmail.com (not shared) Switch account

* Required

Gender *

- Female
- Male
- Prefer not to say
- Other:

What does mental health mean?

Appendix L

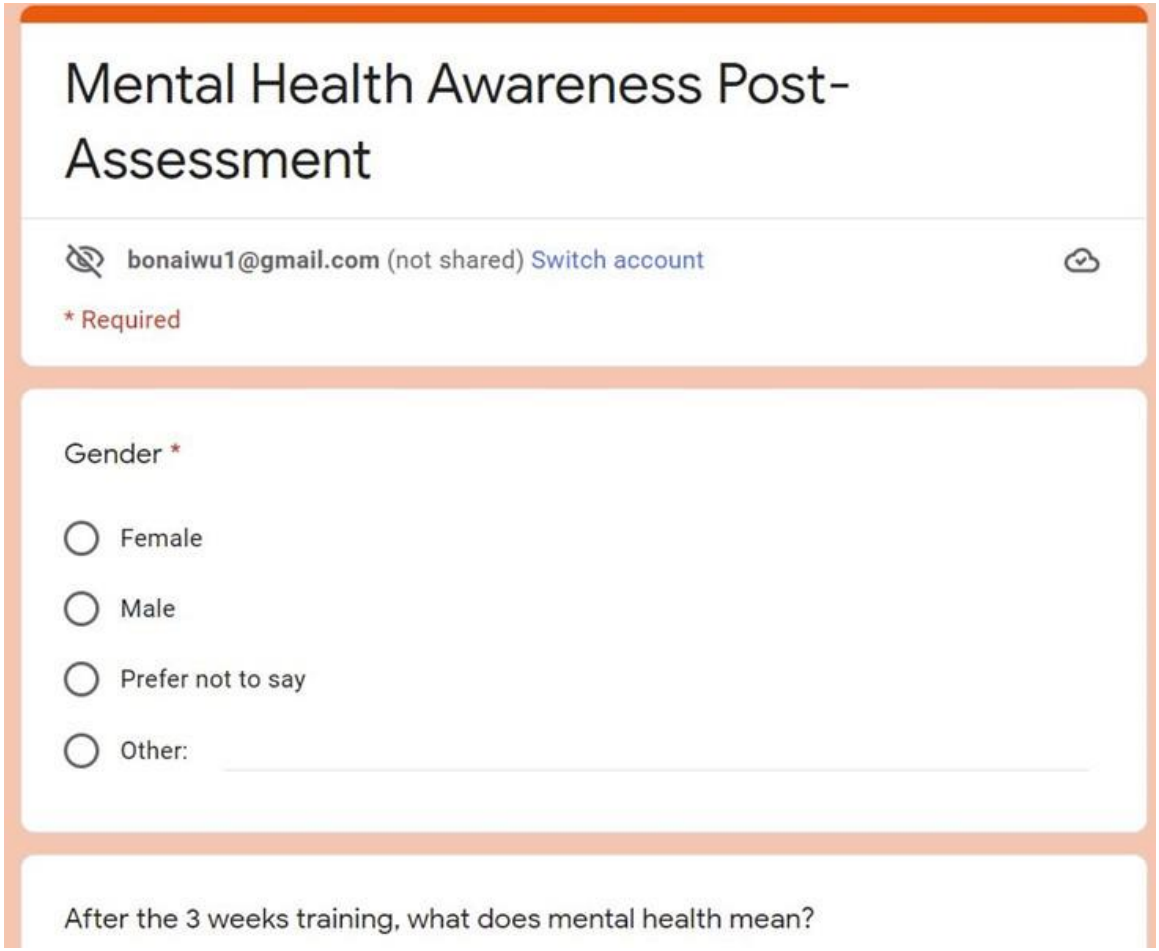
Mental illness Resources

1. Emergency: 911
2. National Domestic Violence Hotline: 1- 800-799-7233
3. National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
4. National Hopeline Network: 1-800-SUICIDE (800-784-2433)
5. Crisis Text Line: Text "DESERVE" TO 741-741
6. Lifeline Crisis Chat (Online live messaging): https://suicidepreventionlifeline.org/chat/
7. Self-Harm Hotline: 1-800-DONT CUT (1-800-366-8288)
8. Essential local and community services: 211, https://www.211.org/
9. Planned Parenthood Hotline: 1-800-230-PLAN (7526)
10. American Association of Poison Control Centers: 1-800-222-1222
11. National Council on Alcoholism & Drug Dependency Hope Line: 1-800-622-2255
12. National Crisis Line - Anorexia and Bulimia: 1-800-233-4357
13. GLBT Hotline: 1-888-843-4564
14. TREVOR Crisis Hotline: 1-866-488-7386
15. AIDS Crisis Line: 1-800-221-7044
16. Veterans Crisis Line: https://www.veteranscrisisline.net
17. TransLifeline: https://www.translifeline.org - 877-565-8860
18. Suicide Prevention Wiki: http://suicideprevention.wikia.com

Finding Support in the Community

The Samaritan Inn (Homeless Shelter) **Number**- (972) 542-5302 **Address**- 1514 N McDonald St, McKinney, TX 75071 **Time**- 9am- 6pm **Website**- www.saminn.org	Frisco Family Services Food Pantry **Number**- (972) 335-9495 **Address**- 9085 Dogwood St, Frisco, TX 75033 **Time**- 9am- 5pm	Feeding Texas **Number**- (512) 527-3613 **Address**- 1524 South IH-35, Ste. 342 Austin, TX 78704 **Website**- www.feedingtexas.org
Frisco Family Services - Food Pantry & Emergency Funds **Number**- (972) 335-9495 **Address**- 8780 Third St, Frisco, TX 75034 **Website**- https://www.texvet.org/resources/frisco-family-services-food-pantry-emergency-funds	Texas Health and Human Services **Number**- (877) 543-7669 or (800) 647-6558 **Address**- 149024 Austin, TX 78714-9024 **Website**- www.yourtexasbenefits.com	Local- Collin County Indigent Health **Number** – 972-548-4702 **Address**- 825 N. McDonald Street, Suite 110 McKinney, Texas 75069 **Time**- Monday–Thursday, 8am–4pm **Website**- www.collincountytx.gov
Texas Medicaid **Number** – 1-800-252-8263 **Email Address**- medicaid@hhsc.state.tx.us **Website**- www.benefits.gov/benefit/1640	Local- Haven Behavioral Hospital **Number** – (972) 476-1705; 469-535-6785- 24/7 **Address**- 5680 Frisco Square Boulevard Frisco, TX 75034 **Website**- www.havenfrisco.com	Riverwalk Ranch – Substance Abuse **Number** – (877) 863-3869 **Address**- 6960 Dick Price Rd, Mansfield, TX 76063 **Website**- www.riverwalkranch.com
Frisco Mental Health Services **Number** – 214-551-7407 **Address**- 255 W Lebanon Road, Suite 224 Frisco, TX 75036 **Email Address**- info@friscomentalclinic.com **Website**- www.friscomentalcare.com	Menninger – Mental Health Services **Number** – (713) 275-5400 **Address**- 12301 Main Street Houston, TX 77035 **Time**- Weekdays from 7 am – 8:30 pm & weekends from 8:30 am to 5 pm **Email Address**- CareCoordination@menninger.edu **Website**- www.menningerclinic.org	National Alliance on Mental Illness **Number** – 703-524-7600 **Address**- 4301 Wilson Blvd., Suite 300 Arlington, VA 22203 **Website**- www.nami.org
Passionately Ever After Counseling Center **Number** – (214) 534-6166 **Address**- 812 Lamp Post Ln, Argyle, TX 76226 **Time**- Monday to Wednesday: 8:00AM - 9:00PM Thursday: 8:00AM - 5:00PM	Santé Center for Healing **Number** – 866.625.2279 **Address**- 914 Country Club Rd. Argyle, TX 76226 **Website**- www.santecenter.com	Life Talk Resource Center **Number** – TEXT or CALL: 214-618-9352 **Address**- 8380 Warren Pkwy Suite 204, Frisco, TX 75035 **Website**- www.lifetalkprc.org
Hope Women's Center **Number** – 972-562-4673 **Time**- Monday - Thursday 9:30-4 Friday - Sunday Closed **Address**- 2740 Virginia Parkway Suite 200 McKinney, TX 75071 **Website**- www.myhope.org	Comfort Care Hospice **Number** – 214-385-4786 **Address**- 5200 Paige Rd. Ste. 500 The Colony, Texas 75056 **Time**- Available 24/7 **Email Address**- info@comfortcarehospice.us	Mosaic Family Services **Number** – (214) 821-5393 **Address**- 12225 Greenville Avenue Suite 800 Dallas, TX 75243 **Website**- www.mosaicservices.org

Appendix M



Mental Health Awareness Post-Assessment

bonaiwu1@gmail.com (not shared) Switch account

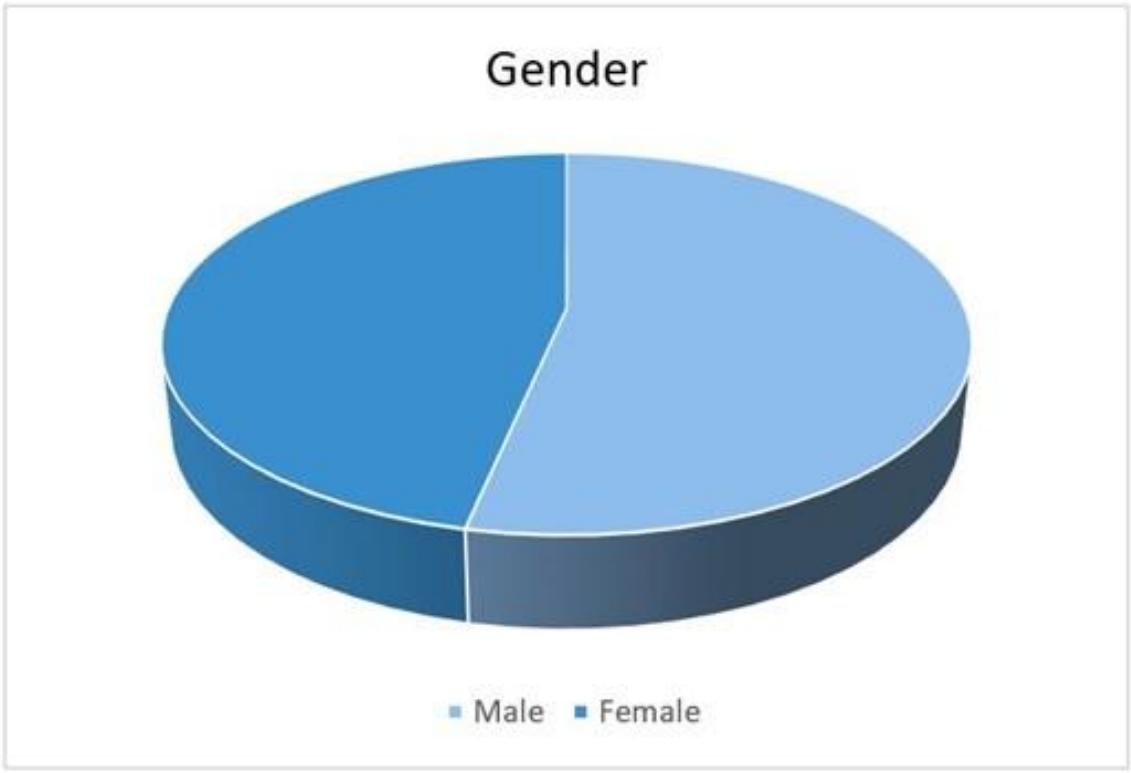
* Required

Gender *

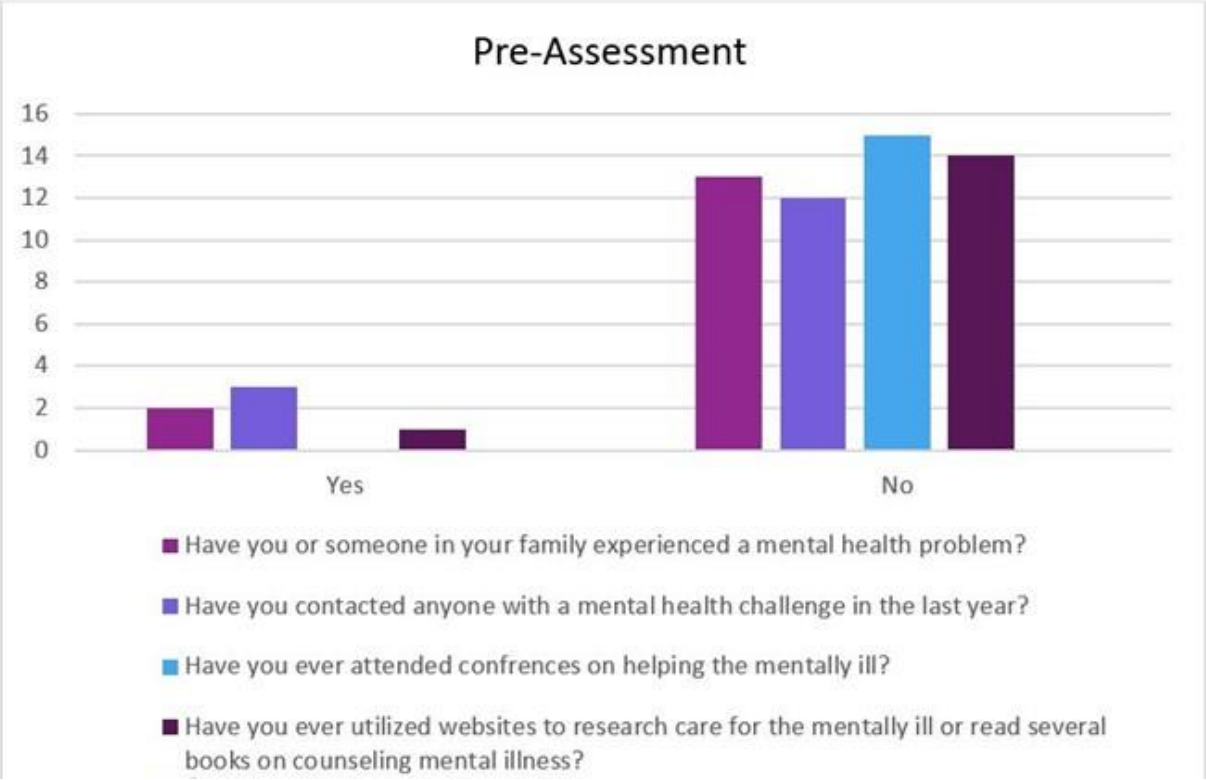
- Female
- Male
- Prefer not to say
- Other:

After the 3 weeks training, what does mental health mean?

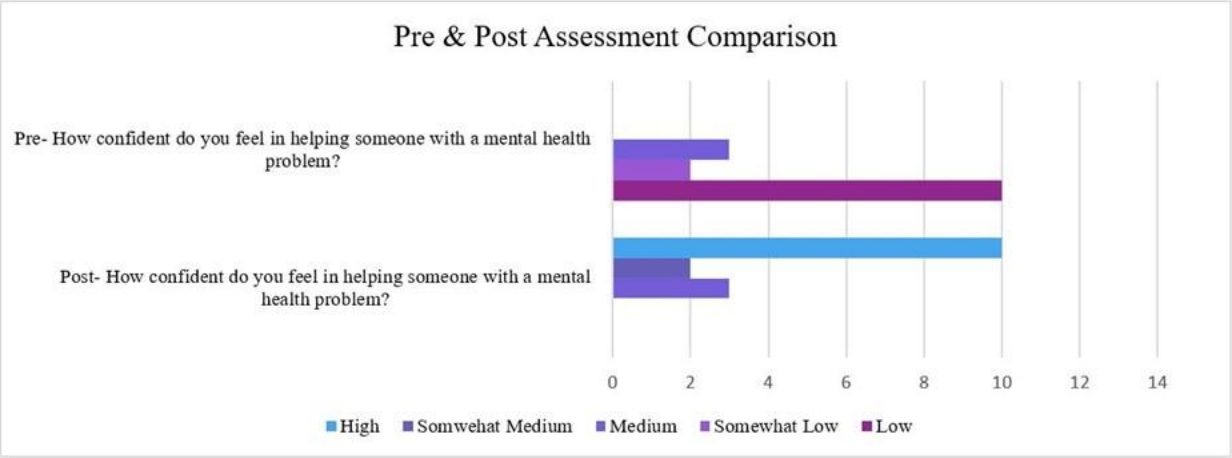
Appendix N



Appendix O


Pre-Assessment
16
14
12
10
8
6
4
2
0
Yes
No
Have you or someone in your family experienced a mental health problem?
Have you contacted anyone with a mental health challenge in the last year?
Have you ever attended confrences on helping the mentally ill?
Have you ever utilized websites to research care for the mentally ill or read several books on counseling mental illness?

Appendix P


Pre & Post Assessment Comparison
Pre- How confident do you feel in helping someone with a mental health problem?
Post- How confident do you feel in helping someone with a mental health problem?
0
2
4
6
8
10
12
14
High
Somwehat Medium
Medium
Somewhat Low
Low