Where Does the Church Stand in Today's Mental Health Landscape?

Noah T. Mursu

Faculty Advisor: Dr. James Murphy

South Dakota State University

Abstract

Religious involvement in care for those living with mental illness has been going on for centuries, and perspectives on it have changed throughout the years. This literature review evaluates the place of religious groups, mainly Christian churches, in today's mental health situation by considering past and present involvement. It incorporates sources regarding different eras of mental hospital reform, modern perspectives of mental health clinicians and clergy, and the current gaps in mental health support among a variety of groups, including veterans, African Americans, and people in developing countries. This review then considers potential future involvement, especially considering how these gaps have been widened by the COVID-19 pandemic. In utilizing these sources, this review finds that effective collaborations are culturally rooted and driven by mutual respect. The results of these are collaborations that not only consider the holistic health of an individual, but also reach a population who may not otherwise receive care for their psychological needs.

Where Does the Church Stand in Today's Mental Health Landscape?

Religious groups have been involved in the care for those suffering from illnesses for thousands of years. However, as ages have passed and understandings of medicine have changed, so too has the relationship between medical practice and religion. Today, the two are very much divorced, meaning that physical health is typically left to physicians and spiritual health is typically left to religious leaders. Mental health, though, is more complicated.

Historically, there has been more hostility between psychology and religion than between religion and other areas of medicine. Religious groups have held a variety of positions on the causes of and best treatments for mental illness, and a number of psychologists and psychiatrists have at times questioned the value of religion (Sullivan, et al., 2014b). Regardless of this, there has been a lot of good done in the past by religious individuals for those living with mental illness. Additionally, the hostility between these groups has been decreasing in recent years to the point that collaboration between religious groups and mental healthcare providers is a real possibility. This is important because today's mental health services are often overwhelmed by the number of people seeking help for mental illness. Additionally, there are many individuals and groups who may not be comfortable reaching out to traditional mental health practitioners. However, some of these people may trust their churches more than medical providers, meaning that mental health services at churches have the potential to those that would otherwise go unseen.

This literature review will consider the past, present, and future of religious involvement in care for those living with mental illness. For the most part, it will consider only Christian involvement, but exceptions will be noted. In doing this, the study will include discussion of the effects of religious groups on waves of asylum reform. Then, it will consider the current

perspectives of mental health practitioners and churches toward one another, specifically considering the perspectives of veterans, African Americans, and those within developing countries. This research will shine light on how the church and mental health practitioners can collaborate, which is especially important in light of the lasting effects of the COVID-19 pandemic, which has increased the burden of mental illness worldwide. In reviewing this literature, this work seeks to answer two questions: is collaboration between religious groups and mental health practitioners is possible, and if so, what is required for it to be effective?

Religious Involvement in Asylum Reform

If one desires to understand modern partnerships between religious groups and mental healthcare providers, it may be beneficial to start with religious involvement in asylum reform, which began in the nineteenth century. In his book entitled *The Second Great Awakening and the Transcendentalists*, Barry Hankins outlines the historical events and implications of evangelical revivals and the rise of transcendentalism in this time. The Second Great Awakening consisted of a series of revivals in response to both the lack of churches as Americans expanded West and the rise of Unitarian and deist ideas in America (Hankins, 2004). Hankins states that these revivals had the stated goal of converting people to the Christian faith, and they varied somewhat based on location or denomination. One of the results of these revivals was a wave of social reforms, including “temperance, anti-dueling, and Sabbath observance” (Hankins, 2004, p. 16). Other big topics included antislavery and feminism; Hankins says that Protestants, especially women, began leading organizations that “sought to aid the handicapped, help the mentally ill, provide relief to the poor, and reform prisons,” (Hankins, 2004, p. 110). Protestants became involved in these reforms because they believed that by reforming society they would usher in Christ’s thousand-year reign. Although that did not happen, the reforms and social changes they led had

widespread effects on society, including in the British Isles (Hankins, 2004), which is where asylum reform began in full force.

Two researchers who set out to explain some of this asylum reform are Michael Brown and Janelle Stanley. Brown seeks to explain why wider reforms happened by using a sociocultural lens, meaning he looks at changes in cultural values throughout society. This, he says, is why reforms really took hold. Stanley, on the other hand, explains the tipping point of these events, namely the creation of a different kind of institution by the Quakers. She describes how the theology of this group profoundly affected their consideration of best care for those living with mental illness. Her work considers events ranging from the nineteenth century to today, but this paper will only consider those during nineteenth century asylum reform.

In his article entitled "Rethinking Early Nineteenth-Century Asylum Reform," Michael Brown offers up a different perspective on asylum reform in the 1800s. Whereas previous scholars have focused on patients themselves and claimed that this reform occurred as a "'natural' response to a self-evident 'evil,'" Brown claims that the reform was the result of widespread cultural changes (Brown, 2006, p. 427). To do this, he focuses in on the case of the York Asylum, which was founded by a group of governors in York, one of whom was Alexander Hunter. Hunter was appointed head physician of the asylum, despite the fact that he had little experience with those living with mental illness. According to Brown, head physicians were chosen based more upon social status than actual qualifications. Additionally, the asylum's board of governors did not involve themselves with daily activities. These factors resulted in mistreatment of patients. Brown says this system did not go unchallenged, but because said challengers made their complaints through the public newspaper, they were simply dismissed by the asylum's governors as they had violated the time's rules of gentlemanly conduct. However,

with time, society's culture and values would change. This led to not only the creation of a new kind of asylum, but also a more effective challenge of existing institutions.

Janelle Stanley establishes in her paper "Inner Night and Inner Light: A Quaker Model of Pastoral Care fot the Mentally Ill" how Quaker theology influenced how this religious group cares for those living with mental illness. Stanley makes the point that Quaker care for this group started with George Fox, the founder of the group. Fox believed that every individual had both darkness and a piece of God within them, which Stanley argues influenced Quaker care for the following centuries. One manifestation of this was the Retreat, which was a Quaker institution created to care for those living with mental illness. The Retreat was established by William Tuke, a Quaker who acted in response to the death of a Quaker woman who died weeks after being admitted to a public asylum. Her death prompted Tuke to investigate the conditions in these asylums where he discovered that those held within were being abused and treated like animals (Stanley, 2010). Tuke believed that the kind of care provided within these asylums was at odds with Quaker theology as established by Fox, so he went to his local Quaker meeting and proposed a new institution for those living with mental illness. This resulted in the Retreat soon thereafter. Where public asylums relied upon borderline barbaric methods of treatment, such as chaining patients to the floor, starving them, or bleeding them with leeches, the Retreat turned to moral treatment in the forms of warm baths, walks outside, hobbies, and talk therapy (Stanley, 2010). After the founding of the Retreat, many similar institutions were founded elsewhere, including Philadelphia and New York (Stanley, 2010). Stanley says that Quaker theology emphasizing the value of the individual was the driving force behind the founding of these institutions. This Quaker way of thinking had profound effects on contemporary reformers and individuals working in mental institutions.

In his article, Brown says that the Retreat was the inciting event in the reforms of York Asylum. He says that Charles Best, the new head physician at the York Asylum, wrote an anonymous letter to a paper claiming that the Retreat and the literature supporting it were thinly veiled attacks against his institution. This prompted a series of responses in the papers from several reformers, including Tuke (Brown, 2006). Although Best argued that these responses violated gentlemanly conduct, the reformers were not deterred. Many joined them, including many religious individuals. After a time, the governors of the asylum eventually invited them to a quarterly meeting where they used the same tactic as with earlier objectors. However, these reformers did not stop. They continued writing to newspapers and began arguing that institutions should be periodically inspected by a non-governor who has no stake in the outcome of the visit. Additionally, many reformers were able to become governors themselves when they discovered a clause saying that the only requirement for doing so was paying 20 pounds (Brown, 2006). They began publishing meeting minutes in papers, making the asylum's practices more open, and one of them even made a surprise visit, after which he documented the asylum's abhorrent practices. Brown points out that these events show how power was shifting away from the elite and towards the middle-class people; as a result, the York Asylum had to change. The new governors opened the institution to the public, and the old staff eventually all left. Brown argues that this was indicative of reforms in many asylums at the time. While these changes were extremely important in changing how institutions for those living with mental illness were run at the time, they did not result in perfect care for those living with mental illness. Regardless, they give an excellent example of how religious convictions can affect the care of those living with mental illness. There would be future reform movements, some of which were also led by religious individuals. The next most prominent one would begin in the 1940s.

Conscientious Objectors in WWII

Steven J Taylor set out to document the history of conscientious objectors (COs) during WWII and the effects they had on mental hospitals both during and after their service in the Civilian Public Service. COs were men who were drafted into the military but for some reason, often theological, refused to serve. The majority of them were either Quakers, Brethren, or Mennonites. The government sent these men to labor camps to conduct manual labor, but many of them desired more meaningful work. As a result, the Selective Service gave them a variety of options for alternative service including work at mental hospitals, which were understaffed due to the war. When the COs arrived at these institutions, they found rampant overcrowding and abuse. The attendants oftentimes left patients naked in rooms covered in human excrement and filth or restrained for hours or days on end. The hospitals gave COs no formal training upon arrival, meaning they had to figure out how to manage patients on their own. Because the patients were accustomed to harsh and violent attendants, the COs sometimes had difficulty dealing with them in a nonviolent manner. COs frequently reported the conditions at these hospitals to outsiders, leading to media coverage and sometimes criminal prosecution (Taylor, 2009). Some particularly reform-minded directors of these institutions liked this about COs and would specifically request them in hopes of rooting out abuse from other attendants. However, some COs hoped to make a larger impact.

One result of this hope was the National Mental Health Foundation (NMHF). Taylor says the foundation began as the Mental Hygiene Program (MHP), which was founded by four COs at Philadelphia State Hospital who hoped to create lasting change in the mental health field. They believed that existing groups, such as the National Committee for Mental Hygiene and American Psychological Association, had grown complacent, and they believed that a group of lay workers

could do better. These COs got support from public figures including Eleanor Roosevelt and former Supreme Court Justice Owen Roberts, resulting in a lot of public attention. With the end of the war and the Civilian Public Service, the MHP became the National Mental Health Foundation. Taylor says the foundation had the broad goals of "educating the public about conditions at institutions, improving the training and elevating the status of attendants, and reforming mental hospital commitment laws," (p. 388), and he says that they went about it with a zeal that made them more effective than existing groups. However, their success did not last, mainly due to disagreements on how the organization should be run and a severe lack of funds. With time, the foundation's goals drifted away from those of the original COs, causing the founders to leave one by one. Eventually, the NMHF merged with a few other contemporary mental health organizations, including those they had criticized for being complacent, creating the National Association for Mental Health (NAMH). By 1953, the same reporters who praised the fervor of the NMHF wrote articles criticizing the NAMH for its abandonment of real action in mental hospitals. Overall, Taylor makes the case that while the conscientious objectors did cause some improvements in the care for those living with mental illness within mental hospitals, they failed to make any real and lasting changes in the field. Taylor says that this does not mean the COs' contributions were pointless, though. They defended their religious beliefs and got the public behind them. Additionally, while the NMHF failed at its mission, it was not the only organization run by COs for those living with mental illness.

Where Stephen Taylor focused on conscientious objectors' advocacy after their time in the Civilian Public Service, Abraham Nussbaum considers the post-war actions of Mennonites who served those living with mental illness more directly. In his paper, he describes how after the war, Mennonites opened a number of mental hospitals designed differently from those in which

they were placed. They provided acute rather than custodial care, had a high staff to patient ratio, were meant to feel more like homes than hospitals, and used the newest psychiatric techniques from a motivation of Christian love (Nussbaum, 2012). These hospitals started with strictly Mennonite personnel, but inevitably there were not enough of these individuals for a full staff. As a result, they began hiring non-Mennonite psychiatrists who wanted to run the hospitals slightly differently. Additionally, the acute model of care these hospitals delivered was similar to the emerging field of social psychiatry, meaning that the hospitals were great candidates for government grants. However, eligibility for these grants meant changing the makeup of their boards of directors to include fewer church personnel. Nussbaum says that while these institutions were still driven by their religious convictions and experiences in the CPS, these factors led them to a model that was less unique from where they began. Despite these changes, Nussbaum makes the point that this movement was successful because it appealed to religious beliefs and utilized the existing resources and networks of the Mennonite church. In his conclusion, he proposes that communities and religious groups today could make a similar impact by considering their own beliefs and using their existing networks. This provides an interesting perspective on today's mental health landscape, allowing the church to begin stepping into the arena of caring for those living with mental illness. The Mennonite example shows these institutions can last, even if doing so means compromising with nonreligious groups. The remainder of this paper will consider the potential feasibility of modern partnerships like this. The first step of this process is to explore the perspectives of today's mental health practitioners on religion and spirituality.

Today's Mental Health Professionals' Views of The Church

Sullivan et al. (2014b) set out to explore the historical perspectives of clergy and mental healthcare providers toward one other and to apply some of these findings to a partnership between the Department of Veterans Affairs (VA) and clergy in rural Arkansas. They report that tension between the two groups greatly increased around the time of the Enlightenment, when scientists were discovering biological causes for disorders previously thought to be spiritual (Sullivan, et al., 2014b). As a result, today's treatments for illnesses, including mental ones, are more scientific than religious. Additionally, these authors say that many mental health clinicians are particularly hostile towards religion. Historically, clinicians have viewed religion as the cause of their patients' suffering or an obstacle to care. However, the researchers say this view has been changing recently. Psychiatrists have begun seeing religion as a factor that can promote their patients' health, even if they still do not fully understand it (Sullivan, et al., 2014b). One result of this is specific research regarding religion and mental illness. Some of these studies seek to understand how religion and spirituality affect coping, and other studies consider the benefits and risks of direct church-based interventions.

Much of the recent research surrounding the relationship between spirituality and mental illness has been correlative in nature; that is, researchers have looked at rates of mental illness within religious populations and compared those rates to those in nonreligious groups. Harold Koenig set out to review several studies of this nature to get a more complete picture of how these two are related. Koenig makes the claim that religion is a coping behavior for individuals suffering from various ailments, including mental illness, because religious beliefs provide a sense of meaning and purpose, an optimistic worldview, a sense of control over one's life, and a supportive community. Additionally, while other coping mechanisms may only be available in

certain circumstances or under certain conditions, religious coping is always readily available for use (Koenig, 2009). In his study, Koenig examines the effects of religious coping on depression, suicide, anxiety, psychotic disorders, and substance abuse, finding that increased religiosity was associated with a variety of better outcomes for all illnesses except for anxiety, for which he found both positive and negative effects based on the situation. For example, those who pray often may feel less anxious, but those who feel God is punishing them tend to be more anxious (Koenig, 2009). Overall, Koenig found that religious coping can be a valuable asset for many living with mental illnesses. This position is one that many modern clinicians are coming to hold, and it is a good first step towards an effective partnership. However, positive attitudes towards religiosity may not always come with positive attitudes towards faith-based interventions. Other studies have been done to explore attitudes towards the latter.

Brian K. Jackson conducted one such study in his 2015 survey of Licensed Professional Counselors (LPCs) in the Southern United States. For reasons that will be explored later in this review, African American clergy often provide pastoral counseling for their congregants. In this kind of counseling, clergy utilize both some psychological practices and theological values to address the problems their congregants bring to them (Jackson, 2015). Jackson wanted to know what licensed counselors thought of these services. In the course of his interviews, Jackson found that the interviewed LPCs understood what pastoral counseling was and that pastoral counselors can act as mediators who can refer their congregants to mental health professionals. However, he also found that the LPCs had some ethical concerns with pastoral counseling. For example, the counselors were worried that clergy would not be prepared to adequately serve clients who disagree with their theological views. Additionally, the LPCs felt additional education or licensure should be required before pastors provide counseling. Based on these results, Jackson

suggested that for future collaboration between mental health providers and clergy to work, the two groups need to openly communicate and work together. This means either better training pastoral counselors or building a referral system allowing pastors to hand off congregants to trusted practitioners. Based on the results studied by Jackson, Koenig, and others, there is a clear trend showing that mental health practitioners are opening up to the possibility of such collaboration. However, effective collaboration here also needs to consider the perspectives of religious individuals and leaders.

The Modern Church's Perspectives on Mental Health

Sullivan et al.'s study (2014b) considers not only the perspectives of clinicians, but also those of clergy. As medicine became increasingly scientific, many clergy began seeing it and specifically psychiatry as a threat to their biblical understandings of disease. For example, the biblical narratives of Jesus calling demons from people led some clergy to view mental illness as an issue that could be resolved with prayer, repentance, conversion, or even exorcism, rather than with methods employed by psychiatrists (Sullivan, et al., 2014b). However, with time, clergy have been becoming less hostile towards clinicians. Some of today's faith communities have even begun recognizing that a partnership between themselves and mental health providers is necessary and have begun implementing programs expressly for this purpose. This provides hope for future collaboration, but it is important to note that not all clergy see mental illness in the same way. In the course of their research, Sullivan et al. discovered that church groups hold a variety of attitudes on mental illness; these attitudes affect how a church may respond to individuals living with mental illness. For example, groups that think mental illness is purely a spiritual problem are less likely to collaborate with mental health practitioners, while those who

think it is not may be more willing to do so. Understanding these perspectives is important in determining whether this collaboration will be effective.

Research has shown that not all groups agree on the best way to deal with mental illness, but it has also proven that many groups hold less stigma than previously thought. Allison Gray's survey of a white evangelical church congregation within the United Kingdom (2001) is one such study. According to Gray, national surveys at the time had shown that negative attitudes towards mental illness within the general public were prevalent. Gray desired to compare the perspectives within a church to those of the public, so she conducted a similar survey. She expected the church's perspectives on mental illness to be negative because evangelicals have historically based their views on stories such as those of demonic possession discussed by Sullivan et al. Contrary to what she anticipated, her survey showed that the congregation was more sympathetic towards those afflicted, more hopeful regarding the treatment of psychotic disorders such as schizophrenia, and less likely to blame people for addictions than was the general population. Gray hypothesized that these views could be because the church's community had higher rates of mental illness than others, increasing the chances of congregants having had personal experience with it; additionally, she said that the teachings on compassion and loving others in the Bible could have influenced their views (Gray, 2001). While Gray's results are only representative of one congregation in the UK and are more than twenty years old today, they still show that many religious groups are more compassionate towards those living with mental illness than previously thought.

Ben Ryan makes the case that in recent years church involvement with mental illness in the UK has been increasing. In his article, he outlines what some of this involvement looks like and seeks to determine what makes Christian approaches to mental healthcare special. In looking

at these programs, Ryan states that many of them are quite small and typically "softer," meaning that they consist of awareness campaigns for issues like loneliness, suicide, or self-image (Ryan, 2018). This leaves the "harder" end of the spectrum, such as direct interventions, to medical professionals. However, he notes that as professionals have become overwhelmed by the sheer number of clients, churches have taken over some of this work. Another thing that Ryan says is that modern organizations with Christian roots or motivations may look the same on the outside as organizations doing the same thing for other reasons. Like the Mennonite hospitals founded by conscientious objectors, they may feel pressure to conform to the rest of society, both because there are fewer Christians to work in them and because funding is scarcer for groups holding Christian values. Regardless of these difficulties, Ryan claims that Christian services should be explicitly Christian for two reasons: many individuals actively seek out Christian organizations before they go to secular organizations, and mental health professionals are seeing the value of spirituality. In light of these facts, Ryan concludes that it is necessary for churches in the United Kingdom to develop their own style of care for those afflicted with mental illness. He says that this distinct style will be formed by biblical, anthropological, and theological perspectives. The biblical approach looks at examples of mental illness outlined in the Bible. Some of these, such as the accounts of possession considered by Sullivan et al., are problematic, but others, such as some Psalms, can provide a sympathetic perspective (Ryan, 2018). The anthropological approach essentially means that the church seeks to care for the whole person, including mentally (Ryan, 2018). Finally, Ryan says the theological framework can be useful but can also provide some obstacles. For example, the theological concept of reconciliation may provide goals for a church ministry for those with mental illness, but the concept of responsibility may make caring for individuals living with mental illnesses affecting their judgement more difficult (Ryan, 2018).

Overall, Ryan makes it clear that he believes that the church has something valuable to offer those living with mental illness, but he fails to make any recommendations for partnerships between it and other institutions. To find such recommendations, one must look to other sources.

One such source was provided by the US Department of Health and Human Services (HHS) in 2004 when the Center for Mental Health Services, which is within the HHS, sponsored a dialogue between those who utilize mental health services and leaders in faith communities (*Building bridges : mental health consumers and members of faith-based and community organizations in dialogue*). While this dialogue did take place several years ago, it addresses trends that are present in many more modern communities. The participants in this dialogue set out to find factors that both promote and hinder recovery when faith-based institutions interact with those living with mental illness, and it went on to create some recommendations based on those factors. The participants determined that faith-based organizations help individuals to recover from mental illness in the following ways: by creating a safe community, through spiritual practices such as prayer and meditation, by understanding mental illnesses, and by understanding the cultural backgrounds of those they are serving. Factors hindering recovery included stigma, lack of outreach to those living with mental illness, lack of openness to the issues within organizations, the schism between religion and mental health practitioners, and lack of validation for spiritual emergencies. Additionally, they went on to discuss system-wide issues hindering recovery, including lack of mental health training for clergy, issues of church and state, lack of links between faith-based organizations and other community organizations, and lack of research to develop evidence-based approaches to this. These positive and negative factors reflect those found by researchers that have already been discussed here, including Koenig, Jackson, and Sullivan et al.

Based on these factors, the participants made a series of recommendations to three separate groups. For the Department of Health and Human Services, they recommend creating curricula to educate faith-based organizations on mental disorders, fostering continuing dialogue between faith leaders and mental health professionals, providing federal assistance where necessary, and fostering future research. For faith-based organizations, they recommend creating a warm environment for mental health consumers, educating clergy and congregants about mental illness and stigma through seminary classes or fact sheets, and fostering relationships with consumers. Finally, for consumers, they recommend developing guidelines and best practices for faith-based communities, volunteering to share stories or assist in programs, and encouraging other consumers to participate in these efforts as well. These ideas and concepts were meant to allow those who read them to create effective partnerships that deal with mental illness in communities across America. However, they are not necessarily restricted to that audience. In the years before and after this conference was held, there has been a lot of research on how Christian groups have partnered with mental health practitioners, and many of them have demonstrated how these recommendations hold up in practice. With these principles in mind, research evaluating programs among various groups can be analyzed. For the purposes of this study, three such groups will be considered: veterans, African Americans, and individuals in developing countries.

Faith-Based Mental Health Programs for Veterans. One group who could stand to benefit from a partnership of clergy and mental health practitioners is veterans. This group has an elevated risk for mental illness compared to others due to experiences they may go through in the service, meaning that they may need to utilize coping mechanisms more than other groups. Sharma et al. (2017) conducted a study on the religious coping of veterans within the population

because, as Koenig's study showed, religious coping can be effective at reducing poor outcomes associated with mental illness. For their study, they conducted a survey of veterans that included questions about their religiosity, sociodemographic factors, a variety of quality-of-life factors, and lifetime experiences of mental illness. Religiosity was grouped into three sections: low, moderate, and high (Sharma, et al., 2017). The results from their survey lined up with those in Koenig's analysis of the impact of religiosity on mental health. High religiosity was associated with lower risk for lifetime posttraumatic stress, major depressive, and alcohol use disorders; additionally, moderate religiosity was linked with lower rates of major depressive disorder and suicidal ideation. It is important to note that because the data for this study was correlational, it is not possible to establish a causal relationship. Additionally, while the researchers were not able to create treatment recommendations based on this data, the link it establishes does provide an interesting question. If increased religiosity is correlated with better mental health outcomes for veterans, do faith-based services provide better care for veterans living with mental illness?

Tatsushi Hirono (2019) set out to determine the perspectives of both veterans and clergy on this question by completing a survey of college students and clergy members. With his survey, he had the goals of determining whether veteran and active military students have a higher risk of suicide than non-military students, the effects of religious ideologies on those statistics, and the potential for use of religious or pastoral counseling as a tool for dealing with suicidal ideations among veterans (Hirono, 2019). His results showed that compared to non-military students surveyed, veteran and active-duty students had higher rates of having considered suicide. Additionally, he found that of the veterans surveyed, several said that faith helped prevent suicide by giving a sense of purpose or comfort. Of the clergy and veterans surveyed, many were also open to pastoral counseling as a way to deal with the mental effects of service

because they believed that pastors could provide unconditional love for those suffering. Overall, Hirono concluded that religion and pastors could provide needed assistance to veterans and soldiers who are living with mental illness; however, this study only explored the potential of such services, not the outcomes. Therefore, more research is required on faith-based interventions for veterans if one is to fully understand their value.

Kopacz, Dillard, Drame, and Quigley (2018) conducted some such research by completing a survey of leaders among both faith-based and non-faith-based organizations for veterans in order to compare the two. The researchers state that many veterans turn to their local churches or other faith-based institutions for support, including with mental health; however, faith leaders may not always understand the military history of veterans within their congregations (Kopacz, Dillard, Drame, & Quigley, 2018). Additionally, non-faith-based organizations may provide a wider range of services or some more specific to veterans. To better understand these differences, researchers designed a short anonymous survey asking respondents questions about their demographics, organizational affiliation, confidence in their ability to assist their service users in mental health concerns, services provided to the community, and the portion of individuals utilizing their services who are veterans. The researchers found that both faith-based and non-faith-based leaders reported feeling either somewhat or very confident in addressing mental health concerns. Additionally, researchers found that respondents working in a faith-based organization reported providing mental health care, suicide prevention, education/outreach, and "other" services far less often than non-faith-based organizations, although they did provide far more spiritual care. Finally, respondents from both groups reported uncertainty as to what percentage of their service users were veterans (Kopacz, Dillard, Drame, & Quigley, 2018). This data led researchers to a few conclusions. First, they concluded that

because of the relatively narrow scope of services provided by faith-based organizations, there is opportunity for faith-based service providers to either expand their services or to create a referral network for their users. The researchers were surprised by the fact that both faith-based and non-faith-based providers were confident in their ability to provide support for those dealing with mental health issues, which they say is key in providing good quality care for individuals. While this survey was itself limited, it shows that the door is open for future work within faith-based groups for those living with mental illness.

Greer Sullivan and others stepped through this door in a study in which they established three faith-based partnerships in Arkansas rural communities. They hoped to bring VA chaplains together with local faith groups to establish programs that were specific to the needs of their communities. Each of these partnerships started with the common goal of informing their respective communities about mental illness and encouraging the use of services (Sullivan, et al., 2014a). The programs began with a VA chaplain who acted as a bridge between mental health services and clergy because they had both religious and mental health experience. Researchers assisted the chaplains in partnering with local community resources and clergy to create local advisory boards who would act as partners in each project. The hope was that these local partners would take charge of the programs. As expected, each of the partnerships looked different based on their individual communities. The program in El Dorado became known as Project SOUTH, and it provided a range of services for veterans through a local church that were not strictly focused on mental health. While researchers noticed this “mission drift,” they allowed it to continue so as not to curb the enthusiasm of those involved with the program (Sullivan, et al., 2014a). The program in Russellville stayed more on-target as it focused on providing educational opportunities and linking mental health providers within local faith communities. The program in

Pine Bluff became known as VIPVets, and it conducted forums on local veteran issues and implemented a program in which a local pastor, who was a veteran himself, assisted other veterans in connecting with VA services (Sullivan, et al., 2014a). It also began focusing exclusively on African Americans rather than individuals of all races. In evaluating these three programs, the researchers recognized that allowing local communities to tailor their projects to their own needs caused a drift from their original mission in some cases; a more clearly defined mission statement could help avoid this drift in the future. However, the researchers still saw that in each program veterans were being assisted in important ways. This is the inherent value of not relying on a standardized program; programs designed by individual communities can meet needs that researchers may not have initially realized were present.

In their work documenting the history of the relationships between clergy and mental health practitioners, Sullivan et al. (2014b) reflect further on the lessons learned from the Arkansas partnership. Here, they focus on the tensions between clergy and mental health practitioners, some of which have already been discussed in this review. In their reflection, the researchers found three sources of tension. The first source of tension was that both clergy and clinicians did not trust that collaboration was possible (Sullivan, et al., 2014b). Some clergy believed that clinicians would drive people away from church and did not believe in the value of spiritual care. Meanwhile, clinicians feared that clergy would discourage the use of mental health treatment and that they were inadequately trained to deal with mental health problems. The second source of tension was that clergy and clinicians both assumed things about the other group rather than seeking true understanding. Third, researchers found that clergy and clinicians were not aware of areas where they could work together to provide services (Sullivan, et al., 2014b). Clergy did not understand referral procedures, and providers did not always understand

the spiritual side of care. Despite these tensions, researchers found that both clergy and clinicians were willing and eager to connect and recognized the value in the other group. The researchers state, "simply introducing community clergy and mental health providers to each other during an informal lunch meeting where barriers to collaboration were often discussed resulted in a series of referrals both to and from the clergy" (Sullivan, et al., 2014b, p. 1278). Overall, Sullivan et al.'s two studies show that collaboration between clergy and clinicians for the care of veterans is possible, and simply getting them in the same room opens doors. However, other groups may have a more difficult time collaborating.

Faith-Based Programs for African Americans. Within Western cultures, minorities have good reason to be skeptical of large institutions due to a history of discrimination and mistrust. In particular, a large body of research has been done on the perspectives of the African American church on the mental healthcare system. Dempsey, Butler, and Gaither (2016) set out in one work to explain these perspectives and give examples of some successful collaborations to guide creation of future partnerships. The researchers begin by explaining the importance of the Black church for the African American community. They say that since the days of slavery, the church has been a safe haven for African Americans facing oppression. In addition to providing religious coping as outlined by Koenig, Dempsey et al. say that the church has functioned as a community hub and made a variety of programs accessible. At the same time, the researchers say that mental health services have typically been unavailable for African Americans in the past for several reasons, including stigma, payment barriers, and lack of trust as most clinicians are white (Dempsey, Butler, & Gaither, 2016). Because these barriers are not present within the church, African Americans tend to rely upon it for support for mental illness; at times, this means turning to their clergy for pastoral counseling. As Jackson and others have discussed, this model of care

is not always perfect, so Dempsey et al. reviewed several other studies to determine how mental health professionals can effectively partner with the Black church to reach African Americans in ways that better meet their needs.

From these studies, researchers made a few recommendations based on common themes. First, they recommended that clinicians attempt to understand and respect the church's culture. Second, they recommended seeking approval and wisdom from the head pastor, who is a trusted leader in the community. Third, they recommended finding a way to integrate mental health services into programs already offered by the church. Finally, Dempsey et al. recommended that practitioners attempt to genuinely engage with the church community. Each of these recommendations requires clinicians to create programs that are specific to individual communities. Doing this shows congregants that practitioners legitimately desire to help them and allows clinicians to establish resources in familiar environments that are backed by community leaders (Dempsey, Butler, & Gaither, 2016). Dempsey et al.'s research showed that understanding the perspectives of African American church leaders is vital to creating lasting partnerships.

Other researchers have conducted similar research and further strengthen themes in the work of Dempsey et al. in hopes of better understanding the perspectives of these church communities. A study by Bilkins, Allen, Davey, and Davey explored some of these perspectives by surveying such leaders in one predominantly black megachurch to learn how often they utilized mental health services, how satisfied they were with those services, and their overall mental health based upon their own experiences of racial discrimination (2015). In analyzing the data from their survey, the researchers found that 44% of the church leaders did not use mental health services and instead chose to rely on their church communities. However, leaders who

reported experiencing more discrimination were more likely to go to mental health service providers. (Bilkins, Allen, Davie, & Davey, 2015). The researchers hypothesized that church leaders first turned to their church communities when they experienced some form of distress, but if that distress became too much for the church to handle, then the leaders would turn to mental health service providers for assistance. The researchers also found that church leaders who reported feeling closer to other African Americans were less satisfied with mental health services than those who felt less close to them (Bilkins, Allen, Davie, & Davey, 2015). The researchers said that this could have been because the practitioners utilized were not African American, meaning that the leaders may not have felt comfortable sharing the details of discrimination with them (Bilkins, Allen, Davie, & Davey, 2015). This research is limited in scope because it only focused on the perspectives of clergy within one church, but it lines up with other research in showing that discrimination is a huge barrier between African Americans living with mental illness and mental health practitioners. Unless this barrier can be overcome, churches and mental health providers are not going to be able to collaborate.

Fortunately, research has shown that these barriers can break down under certain circumstances. Hurricane Katrina, which caused extensive damage to the Southern coast of the United States, was one such occasion as minorities, including African Americans, were affected disproportionately by the storm. As a result, many turned to their church leaders, who were sometimes aided by outside organizations (Aten, Topping, Denney, & Bayne, 2010). Aten et al. set out in a series of interviews to determine how church leaders were dealing with this increased need and how mental health professionals assist them. In analyzing the results of their survey, the researchers found five distinct themes for potential collaboration. First, they found that pastors desired for more information about mental illness for themselves and their congregations as they

were unsure of where or when to refer their congregants who needed more intensive care. Second, they found that the pastors desired assistance in determining the needs of their congregations. Third, pastors expressed how they wish they had assistance in making plans both before and after the disaster. Fourth, pastors said that there was a need for more clinical services in their area. Finally, pastors made it clear that they believed that the spiritual nature of their services was still beneficial to their congregations, and they hoped future partnerships would keep that in mind (Aten, Topping, Denney, & Bayne, 2010). This study adds to the body of research regarding church leaders and clinicians by indicating that leaders can be open to collaboration with mental health professionals, especially in times of crisis and when they have had opportunities to work with them in the past. This is important today in light of the COVID-19 pandemic, which is greatly impacting African Americans. Additionally, it gives examples of specific resources needed by leaders to establish initiatives for their congregants. What it fails to consider, though, are the responses of these congregants when their churches try to establish these initiatives.

A survey of congregants in a Midwestern black church by Campbell and Winchester (2020) seeks to address this concern. This church was faced with the possibility of expanding its mental health services into a full clinic and wanted to learn what its congregants thought of the expansion. The researchers found that 89% were in favor of the expansion, 10% were unsure, and 1% were opposed to the expansion. Additionally, the researchers found several common themes present within responses to a short answer question in which respondents explained their positions. The first theme was that the new counseling center would fulfill an unmet need within the community since other local mental health centers had recently closed and violence and poverty greatly affected the area. Second, respondents believed that expanding the counseling

services would address stigma within the community and teach individuals where to go for assistance. The final theme was that a counseling center within the church would address the holistic needs of African Americans and of Christians in general. While these three themes were present within those in favor of the expansion, those uncertain had a common concern that it would not be sufficiently staffed to meet the need or with individuals who understand the community (Campbell & Winchester, 2020). However, these individuals were in the clear minority and there was overwhelming support for the expansion as a whole. It is important to note that this study is limited in that it only surveyed individuals from one church congregation; however, it is in line with the existing body of research on this demographic group. Another limitation is that 91% of those surveyed were women, leaving men underrepresented (Campbell & Winchester, 2020). This is a problem in light of the fact that African American men face more mental health problems compared to African American women. Regardless of these limitations, this survey clearly demonstrates that culturally appropriate mental health initiatives in African American churches have been supported in the past. Knowing this, the next step is to consider the effectiveness of some of these programs.

Hankerson and Weissman (2012) conducted a review of eight studies of church-based mental health programs in order to determine their effectiveness; additionally, they isolated common factors that led to this effectiveness. To do this, they gathered a sample of studies on mental health interventions for African Americans in churches, excluding those that focused on pastoral counseling. Out of the eight studies they found, five were related to substance use, one focused on depression and anxiety among women, one explored hypothetical help-seeking behaviors regarding suicidal thoughts among adolescents, and one studied the impacts of a support group for those caring for a family member with mental illness (Hankerson & Weissman,

2012). Based on these studies, the researchers drew a few conclusions. First, church-based interventions are effective because they are tailored specifically to black culture. Second, many churches reportedly do poorly at addressing moral issues such as sex and criminal activity. Third, they concluded that black adolescents may be more willing to utilize community-based resources than professional resources, although adolescent males were less likely to use even these. Based on these results, it is evident that while church interventions have the potential to reach a broader set of individuals, they are limited in the topics they cover in ways that secular agencies are not. A partnership between the two has the potential to utilize the strengths of both and truly meet the needs of this population. While this study did consider programs over a thirty-year span, its sample size was quite limited. Regardless of this fact, the researchers are still encouraged by the fact that these programs appear to be effective in reaching a population in need, and they recommend that mental health services utilize the church more in the future.

Even within the black church, there are individuals who might especially benefit from collaborations with mental health agencies. One such group is black males. In light of this, Robinson, Jones-Eversley, Moore, Ravenell, and Adedoyin (2018) set out to understand what the church must do to more effectively reach this population. They make the point that males deal with masculinity expectations on top of factors common to African Americans; additionally, past relief policies have frequently focused on mothers, children, or the elderly, leaving males without aid (Robinson, Jones-Everslay, Moore, Ravnell, & Adedoyin, 2018). The researchers say that this leads to black males utilizing mental health services least compared to other ethnicities and genders. The researchers believe that the black church is in an excellent position to provide these services for this group so long as they are tailored to it. To best do this, they recommend future researchers keep in mind the effects of both gender and religion on mental health in order to find

culturally appropriate interventions and determine who is best equipped to lead them. This could mean training existing clergy, or it could mean creating groups facilitated by trained mental health professionals. Regardless of the details, the researchers are hopeful about the potential of a church-based intervention. Robinson et al.'s conclusions are representative of the body of research in that they conclude that there are a variety of ways in which outside mental health agencies can work with churches to provide for African Americans living with mental illness. Models that incorporate the cultural strengths of the church and professional strengths of clinicians have great potential to benefit the African American religious community. This sentiment strongly echoes that which was found within the partnerships for veterans, and especially those from Sullivan et al. in saying that the most effective programs are those that take into account the actual needs of a community and seek to meet them as best as possible. With this in mind, the next group to consider is those living in cultures even more isolated from mental health agencies.

Faith-Based Programs in Developing Countries. Examples within African American and veteran populations show that there are populations in America who would benefit from a partnership between churches and mental health agencies, but there are many such populations around the world. In a paper put out by the World Health Organization, Kohn, Saxena, Levav, and Saraceno (2004) conducted an analysis of existing studies to determine the percentage gap between people living with and those being treated for mental illness in a variety of countries. To do this, they used medical journal databases to find studies on the prevalence of a variety of mental illnesses in countries. Then, they found studies on service utilization in those same countries and used this data, along with population demographic information, to calculate the treatment gap for each disorder and country for which there was data. Based on these

calculations, the researchers determined that worldwide the treatment gap was quite wide with the mean percentages exceeding 50% for all but two of the disorders they considered. Their study did not even consider many developing countries where treatment is even rarer but data was not available, nor did it account for treatment effectiveness. As a result, the researchers say it is entirely possible that the situation is worse than their statistics would lead one to believe (Kohn et al, 2004). To address this gap, the World Health Organization put out some recommendations, including empowering community facilities to take on some of the burden of care. The church could act as one such facility. To explore whether it is feasible for the church to actually do this, this review will now turn to research from developing countries.

In one example of such research, Kuruvilla George set out to understand the perspective of the Pacific Island nation of Vanuatu's church in his brief work on the state of mental healthcare there (2010). At the time of his study, George says care for those living with mental illness was extremely limited in Vanuatu. In the entire country of 202,200 people, 92% of whom identify as Christians, there were only two beds dedicated to the care of those living with mental illness and no psychiatrists specializing in mental illness. In his study, George surveyed church members to learn their thought on mental illness. He found that of those surveyed, more than half thought mental illness was caused by sin or weak faith, and many also thought it could be due to curse or possession (George, 2010). Clearly, work must be done to address both the treatment gap and stigma there. Although George's research is very small scale, it is indicative of perspectives in other nations.

Ghana is a country in which there is considerable hostility and misunderstanding between the mental healthcare system and traditional or religious institutions (Osafo, 2016). In his work, Joseph Osafo says that overcoming this is vital to caring for Ghana's people, and he proposes

ideas to make this a reality. Osafo says that in Ghana, spiritual healthcare was extremely prevalent in the past, but colonial powers turned against it both because it was “unchristian” and because of the rise of biomedical treatments (Osafo, 2016, p. 495). Osafo says that modern clinicians are not open to discussing spirituality with their patients and do not trust spiritual leaders to provide mental healthcare. Meanwhile, spiritual leaders demonize mental illness and sow distrust of medical institutions among their congregants. Based on these challenges, Osafo makes a few recommendations for moving forward. First, he recommends both groups start by adopting a biopsychosocial-spiritual framework when dealing with mental illnesses, which considers both biomedical and spiritual factors (Osafo, 2016). From there, he recommends that mental health providers seek to understand patients’ spirituality and that religious leaders seek to understand that some of their practices can cause poorer mental health. Once this is done, Osafo says that religious leaders can take on some of the burden of care for those living with mental illnesses. Like the World Health Organization, Osafo says this would be effective in closing the treatment gap there. His last recommendation is that mental health providers should be taught about the importance of spirituality. Psychiatry and social work programs in Ghana lack this kind of information and adding it would break down some of the barriers between clinicians and patients. Overall, Osafo's article emphasizes the importance of education and mutual understanding in forging a collaboration between the spiritual and orthodox spheres of care within Ghana. Clearly, work must be done to increase the efficiency of partnerships like this, but, as Osafo notes, it has been accomplished in the past in other countries.

Iheanacho, Obiefune, Ezeanolue, Ogedegbe, Nwanyawu, Ohaeru, and Ezeanofue (2014) facilitated one such partnership when they studied the feasibility of implementing mental health screening procedures into an existing church-based program for pregnant mothers and their

families. The researchers developed a program in which 144 church-based health advisors administered a questionnaire determining level of psychological distress (Iheanacho, et al., 2014). Of those who elected to participate, 93% completed the questionnaire, 21.7% of whom were found to have significant psychological distress and 3% were found to be in severe distress. These results showed the researchers that screening procedures like these are effective at reaching those in third-world countries who have been known to mistrust mental health agencies. This program initially set out to refer individuals with high levels of distress to a nearby hospital for assessment, but they found that there was a shortage of clinicians there. Therefore, they recommended that along with implementing programs similar to theirs in churches, others should implement programs in which religious leaders are trained as frontline counselors with the ability to refer individuals to the hospital as necessary. This lines up with the recommendations of Osafo and the World Health Organization. Overall, this program provides one example of how utilizing the church as a resource in developing countries can go well, but it is not the only one.

Puffer, Green, Sikkema, and Broverman (2016) designed a family-based intervention to tackle both mental health and HIV/AIDS among adolescents in Kenyan churches. The researchers utilized a family-based model because research has shown that healthy familial relationships can provide protection from a variety of risk factors, and they delivered it in churches because they are established community hubs in Kenya. The program was designed to improve communication within families, especially regarding economic, emotional, and HIV-related topics (Puffer, et al., 2016). It did this by having lay providers demonstrate and then facilitate healthy behaviors for families and then breaking them up into groups of youth and parents for further instruction and reflection. To measure their success, the researchers had participants complete a survey before the intervention, one month after intervention, and three

months after the intervention in two churches which gauged parent-adolescent communication, knowledge about HIV, perceived parental support, self-esteem, depression, anxiety, and risky sexual behaviors. They hypothesized that their program would lead to better parenting and lower risk of HIV, with secondary effects including better mental health and less risky sexual behavior.

In analyzing their data, the researchers came to a few conclusions. First, they found their program improved relationships throughout families, not just between those who attended the interventions; this means the changes are more likely to last (Puffer, et al., 2016). Additionally, while the data showed little change in mental health outcomes for participants, the researchers believed that the improved parenting practices would act as a buffer for future mental illness (Puffer, et al., 2016). While this study was promising, it was lacking in a few areas. Namely, there was no long-term follow-up to prove the interventions' effectiveness, and the sample did not specifically target those living with mental illness. Therefore, it is not currently possible to definitively conclude whether the origram leads to better mental health outcomes. Even if it does not provide a model specific to mental illness though, this program still provides an example of an intervention conducted in a church that impacted its community.

As a whole, programs such as these have real potential to impact many in developing countries, which is especially helpful in light of the large gaps currently present in care for those living with mental illness. In fact, research has shown that church-based interventions can be effective in a variety of populations. Because churches and other religious organizations are oftentimes already trusted institutions in their communities, they have the potential to break down barriers and provide culturally relevant models of care for whomever they serve. This is more important today than ever before in light of the COVID-19 pandemic.

The Effects of and Responses to the COVID-19 Pandemic

The COVID-19 pandemic has had a profound effect on the burden of mental health of a huge variety of groups. Auerbach and Miller set out to explain some of the effects that the pandemic is having on Americans' mental health in an editorial published in the *American Journal of Public Health* (2020). In their editorial, they liken the effects of the pandemic on mental health to those after 9/11, the H1N1 outbreak, and the Haitian earthquake (Auerbach & Miller, 2020). They make the point that many Americans are living in areas where they do not have easy access to mental health professionals, and access can become even more difficult if they have to quarantine. Additionally, disruption of routine and fear of illness are causing extreme stress, and isolation from loved ones is leading to loneliness. They conclude that it is necessary to bolster the responses to mental illness in the United States to reach those in need, and they recommend doing so on a federal rather than state level. The federal regulations they recommend would be good for ensuring that everyone is getting some care, but they would likely fail to meet the specific needs of the entire American population because different populations have been affected differently by the pandemic. As has been demonstrated repeatedly throughout this study, a community-based approach could do a better job of meeting these specific needs.

One study that focuses on such differences between populations was conducted by Runkle, Sugg, Yadav, Harden, Weiser, and Michael (2021) who utilized data from a national mental health texting hotline to compare utilization between the pre-pandemic and pandemic period. The service whose data they used is a nonprofit organization who provides support for individuals who text in times of crisis; these texts are tagged in a variety of ways based on the issues being discussed. Additionally, while the data was kept anonymous, demographic characteristics such as gender, ethnicity, and sexual identity were collected where possible

because they have been identified as covariables for mental illness in some studies (Runkle, et al., 2021). In analyzing their data, the researchers found that there was an increase in texts relating to stress, abuse, isolation, and substance abuse during the pandemic compared to prior to it. Other variables changed somewhat, although not all at the same magnitude (Runkle, et al., 2021). While the researchers found that all groups experienced increases in responses, some were affected more. Blacks and Hispanics experienced higher increases in bereavement compared to whites, and gender nonconforming individuals had rates even higher than that (Runkle, et al., 2021). This shows that while all populations need support during and after the pandemic, some groups may need more than others. While such support had come from institutions such as schools in the past, closures of such institutions had blocked support. Overall, while this study is innovative in its method of data collection and valuable in what it found, it still has some limitations. First, only 20% of participants provided demographic data, which weakened the study's ability to correlate outcomes. Additionally, it was largely focused on adolescents and youth because that is the age group that utilized the text service most. Finally, it only includes data from early in the pandemic, leaving questions on how the needs of these groups have changed in the years since. Regardless, this study still provides statistical evidence for the fact that the mental health of minority groups was particularly impacted during this period. This provides support for the argument that a community-based response to the effects of the pandemic may actually be more effective than the wide-sweeping ones suggested by Auerbach and Miller.

El-Majzoub, Narasiah, Adrien, Kaiser, and Rousseau (2021) documented one such community-based intervention that involved a partnership between the city of Montreal and two minority religious groups. They say that when the city put public safety measures put in place in

response to the pandemic, they oftentimes failed to consider the needs of minority groups within the population (El-Majzoub, Narasiah, Adrien, Kaiser, & Rousseau, 2021). In light of this, the researchers set out to conduct a series of negotiations with a Jewish group and a Muslim group in order to better meet their needs. For the Jewish group, these negotiations involved determining how to best keep the mikvah open and how to reduce experiences of discrimination from police and neighbors in communities with Orthodox Jews. For the Muslim community, the negotiations involved establishing meeting practices in mosques and determining how to get food from mosques to families during Ramadan. These negotiations led to some compromises, meaning that these religious groups got some, but not all, of what they wanted. The researchers noted that this partnership was particularly effective because it not only encouraged faith organizations to comply with government organizations, but also encouraged these government organizations to learn about the perspectives of faith-based groups. It also allowed people within these communities to continue with some of their religious practices, which are important for coping. While this study did not consider partnerships with Christian churches or focus specifically on mental health services, it does provide a sort of framework for working with minority faith groups during the pandemic. This model of mutual respect and collaboration will no doubt be useful in research that does consider Christian groups and mental health.

African Americans are another group who has reportedly faced similar challenges to other minority groups as a result of the pandemic. In a perspective article published in the *Journal of Racial and Ethnic Disparities*, DeSouza, Parker, Spearman-McCarthy, Duncan, and Black (2020) document their first-hand perspectives of the effects of the COVID-19 pandemic on African Americans specifically within the Christian church. They note that although COVID is affecting individuals of all races, African Americans are dying at a disproportionate rate

compared to others, which they attribute to “societal, racial and healthcare disparities” (DeSouza, Parker, Spearman-McCarthy, Duncan, & Black, 2020, p. 7). In light of this and the history of mistrust already described in this review, DeSouza et al. note the significance of the fact that black churches have had to close due to the pandemic, saying, “for the first time in our history, African Americans must cope with the contextually valid fears of COVID-19 without physical access to our religious havens to alleviate mental distress” (2020, p. 9). They also say that even as churches began reopening, many still feared attending services again as a result of the virus. In handling this issue, they give some recommendations to providers. Many of these, such as remaining cognizant of the effects of racism on mental health, have already been discussed, but others are novel. For example, they recommend that providers assist African Americans in finding ways to receive spiritual comfort, giving the example of finding someone to help them get the technology required to watch a church service online. They also note that it may be beneficial to create resources specific to African American faith-based communities to assist in coping with mental illness or other issues caused by the pandemic. They conclude by once more noting the importance of mindfulness as clinicians help those affected by current times; creating or modifying programs with this in mind will lead to better help to those who really need it.

One example of a program created specifically for the African American church was described briefly by Thompkins, Lai, Barclay, Goldblum, Hansell, and Brown (2020). This program, entitled Project Trust, wound up consisting of a series of videos designed to give pastors resources to convey accurate public health information to their congregations in light of the COVID pandemic. Themes included the disruption of rituals, concerns regarding groups who were not following public health guidelines, reactions to trauma, and realizations of the reality of disparities within these communities. They were tailored for the black church, meaning they

utilized specific cultural language to convey their information. While work was still being done on this project at the time of the publication of this article, what had been documented so far provides a framework for what future resources for church communities could look like. By utilizing a video medium, it reaches far more individuals than it could if it were in-person and overcomes one of the primary obstacles presented by the pandemic. This program provides one example of how churches can step in to help African American individuals who are suffering as a result of current events.

Another Christian group that is being affected by the pandemic is the Orthodox Church in America. Schieffler and Genig (2021) set out in their review of studies to determine what path forward the church should take in responding to the mental health burden caused by the pandemic. Because there is little research available specific to Orthodox Christians, the researchers used data from other similar populations (Schieffler & Genig, 2021). For example, because many Orthodox churches are made up of immigrants and minorities, researchers used information from studies on Hispanic church programs or some Black church programs. Based on this review, they find that while clergy may desire to form partnerships with outside agencies for the good of their congregants, they may be unable to do so because they may not be able to recognize mental illnesses. To overcome this, the researchers recommend that clergy begin seeking out information about mental illness and familiarizing themselves with the work of community mental health organizations. This acts as a step to effective future partnerships that will help their congregations to heal from the trauma caused by recent events. By seeking to understand what mental illness looks like and the interventions that are already available, churches can do a better job of collaborating with these agencies and addressing the needs created by this pandemic.

The body of research regarding the effects of the COVID pandemic, especially on religious groups, is still developing at the time of this paper's writing, but that which has been compiled shows that collaboration between these groups and government or other secular institutions is vital in the recovery efforts. Studies have shown that both religious leaders and mental health providers should be reaching out to each other in order to forge effective partnerships rather than waiting to be reached out to. This will allow these groups to get out in front of any unforeseen effects of this pandemic and to really help those in need. No doubt, the solutions will need to be creative at times, and they may require some compromises. Yet, they are going to be extremely important in reaching those who are most affected by this pandemic.

Conclusion

As a whole, both history and current research has shown that there is great potential for good when mental health clinicians and religious groups interact. While clinicians may better understand mental illness and be better trained in providing care for these diseases, the existing trust and structures of religious institutions are strengths simply not present in many of today's mental health services. A collaboration between the two would be extremely beneficial and have the potential to serve groups of people who may not otherwise get help with their mental illnesses. No two collaborations are going to look exactly the same; rather, as Sullivan et al. and other researchers have demonstrated, each must be based around the culture and needs of its own community. This is the inherent strength of community organizations such as the church.

With that being said, there are some common characteristics of effective collaborations that can be drawn from this research. The first of these is that effective collaborations simply begin with getting mental health clinicians and clergy in the same room to talk. Doing this can begin breaking down barriers that can lead to continued stigma if allowed to fester. This leads

into the second key characteristic, which is that effective collaborations are made up of mutual respect. As has already been stated, each of these groups has something beneficial to bring, and continually recognizing this is important if these partnerships are going to last long term. Third, clergy must be provided resources and education in order to better serve their congregations. The fact is, not all clergy know a lot about mental health, and clinicians are not always going to be at churches to answer questions. Providing education and resources has the potential to effectively fill these gaps. Fourth is that it is important to establish a referral network in which clergy can send individuals to clinicians when they feel ill equipped to meet their needs. Clergy cannot do it all. They cannot simply replace therapists, psychiatrists, psychologists, and other medical professionals. However, they can stand in a gap and serve their congregants. Finally, it is vital that these partnerships are founded on what already exists and are encouraged to grow as population needs change become more apparent. Doing this builds upon a church's strengths and ensures that it is actually effective in serving people well.

Researchers have been recommending and implementing collaborations like this for decades, but the need for them has greatly increased in the wake of the COVID-19 pandemic. The pandemic's effects on mental health have been widespread, but especially so among the world's most vulnerable populations, some of whom may not trust medical institutions. Therefore, unless these two different kinds of institutions reach out together, it is entirely possible that some will never get the support they need. Past and present evidence shows that this collaboration is more than feasible; in fact, it is already happening around the world. The process has come with growing pains, but the gap between those who care for spiritual and those who care for mental health is slowly being bridged. One can only hope that this leads to even better quality of care for many populations in the future.

References

Aten, J. D., Topping, S., Denney, R. M., & Bayne, T. G. (2010). Collaborating With African American Churches to Overcome Minority Disaster Mental Health Disparities: What Mental Health Professionals Can Learn From Hurricane Katrina. *Professional Psychology, Research and Practice, 41*(2), 167-173.

Auerbach, J., & Miller, B. F. (2020). COVID-19 exposes the cracks in our already fragile mental health system. *American Journal of Public Health, 110*(7), e1-970.

Bilkins, B., Allen, A., Davie, M. P., & Davey, A. (2015). Black Church Leaders' Attitudes About Mental Health Service: Role of Racial Discrimination. *Contemporary Family Therapy, 38*(2), 184-197.

Brown, M. (2006). Rethinking Early Nineteenth-Century Asylum Reform. *The Historical Journal, 49*(2), 425-452.

Campbell, R. D., & Winchester, M. R. (2020). Let the Church Say…: One Congregation's Views on How Churches Can Improve Mental Health Beliefs, Practices and Behaviors among Black Americans. *Social Work and Christianity, 47*(2), 105-122.

Dempsey, K., Butler, S. K., & Gaither, L. (2016). Black Churches and Mental Health Professionals: Can This Collaboration Work? *Journal of Black Studies, 47*(1), 73-87.

DeSouza, F., Parker, C. B., Spearman-McCarthy, E. V., Duncan, G. N., & Black, R. M. (2020). Coping with Racism: a Perspective of COVID-19 Church Closures on the Mental Health of African Americans. *Journal of Racial and Etnic Health Disparities, 8*(1), 7-11.

El-Majzoub, S., Narasiah, L., Adrien, A., Kaiser, D., & Rousseau, C. (2021). Negotiating safety and wellbeing: The collaboration between faith-based communities and public health during teh COVID-19 pandemic. *Journal of Religion and Health, 60*(6), 4564-4578.

George, K. (2010). Vanuatu: happiest nation on earth, mental health and the Church. *Australian and New Zealand Journal of Psychiatrity, 18*(1), 63-65.

Gray, A. J. (2001). Attitudes of the public to mental health: a church congregation. *Mental Health, Religion & Culture, 4*(1), 71-79.

Hankerson, S. H., & Weissman, M. M. (2012). Church-Based Health Programs for Mental Disorders Among Africam Americans: A Review. *Psychiatric Services, 63*(3), 243-249.

Hankins, B. (2004). *The Second Great Awakening and the Transcendentalists.* Westport: Greenwood Press.

Hirono, T. (2019). Preventing soldiers' and veterans' suicide by pastoral counseling and mental health treatment. *The Journal of Pastoral Care & Counseling, 73*(3), 176-182.

Iheanacho, T., Obiefune, M., Ezeanolue, C. O., Ogedegbe, G., Nwanyanwu, O. C., Ehiri, J. E., . . . Ezeanolue, E. E. (2014). Integrating mental health screening into routine community maternal and child health activity: experience from Prevention of Mother-to-Child HIV transmission (PMTCT) trial in Nigeria. *Social Psychiatry and Psychiatric Epidemiology, 50*(3), 489-495.

Jackson, B. K. (2015). Licensed Professional Counselors' Perceptions of Pastoral Counseling in the Africal American Community. *The Jounral of Pastoral Care & Counseling, 69*(2), 85-101.

Koenig, H. G. (2009). Research on religion, spirituality, and mental health: A review. *Canadian Journal of Psychiatry, 54*(5), 283-291.

Kohn, R., Saxena, S., Levav, & Saraceno, B. (2004). The treatment gap in mental health care. *Bulletin of the World Health Organization, 82*(11), 858-866.

Kopacz, M. S., Dillard, S. B., Drame, E. F., & Quigley, K. S. (2018). Faith-Based Groups as a Bridge to the Community for Military Veterans: Preliminary Findings and Lessons Learned in Online Surveying. *Journal of Religion and Health, 58*(1), 236-245.

Nussbaum, A. M. (2012). The Mennonite Mental Health Movement: Discipleship, Nonresistance, and the Communal Care of People With Mental Illness in Late 20th-Century America. *The Journal of Nervous and Mental Disease, 200*(12), 1088-1095.

Osafo, J. (2016). Seeking Paths for Collaboration between Religious Leaders and Mental Health Professionals in Ghana. *Pastoral Psychology, 65*(4), 493-508.

Puffer, E. S., Green, E. P., Sikkema, K. J., Broverman, S. A., Ogwang-Odhiambo, R. A., Pian, J., . . . Nezu, A. M. (2016). A Church-Based Intervention for Families to Promote Mental Health and and Prevent HIV Among Adolescents in Rural kenya: Results of a Randomized Trial. *Journal of Consulting and Clinical Psychology, 84*(6), 511-525.

Robinson, M. A., Jones-Everslay, S., Moore, S. E., Ravnell, J., & Adedoyin, A. C. (2018). Black Male Mental Health and the Black Church: Advancing a Collaborative Partnership and Research Agenda. *Journal of Religion and Health, 57*(3), 1095-1107.

Runkle, J. D., Sugg, M. M., Yadav, S., Harden, S., Weiser, J., & Michael, K. (2021). Real-Time Mental Health Crisis Response in the United States to COVID-19: Insights From a National Text-Based Platform. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*.

Ryan, B. (2018). The Church and Mental Health: Theological and Practical Responses. *Zygon, 53*(2), 409-426.

Schieffler, D. A., & Genig, J. (2021). The Orthodox Church and the Mental Health Burden of a Pandemic: A Narrative Mini-Review. *Journal of Religion and Health, 60*(5), 3209-3216.

Sharma, V., Marin, D. B., Koenig, H. K., Feder, A., Iacoviello, B. M., Southwick Steven, M., & Pietrzak, R. H. (2017). Religion, spirituality, and mental health of U.S. military veterans: Results from the National Health and Resilience in Veterans Study. *Journal of Affecive Disorders, 217*, 197-204.

Stanley, J. (2010). Inner Night and Inner Light: A Quaker Model of Pastoral Care fot the Mentally Ill. *ournal of Religion and Health, 49*(4), 547-559.

Sullivan, G., Hunt, J. B., Haynes, T. F., Bryant, K., Cheney, A. M., Pyne, J. M., . . . Richison, R. (2014a). Building Partnerships With Rural Arkansas Faith Communities to Promote Veterans' Mental Health: Lessons Learned. *Progress in Community Health Partnerships, 8*(1), 11-19.

Sullivan, S., Pyne, J. M., Cheney, A. M., Hunt, J., Haynes, T. F., & Sullivan, G. (2014b). The Pew Versus the Couch: Relationship Between Mental Health and Faith Comunities and Lessons Learned from a VA/Clergy Partnreship Project. *Journal of Relgion and health, 53*(4), 1267-1282.

Taylor, S. J. (2009). *Acts of conscience: World War II, mental institutions, and religious objectors.* Syracuse: Syracuse University Press.

Thompkins, F., Goldblum, P., Tai, T., Hansell, T., Barclay, A., Brown, L. M., & Kendall-Tackett, K. (2020). A Culturally Specific Mental Health and Spirituality Approach for African Americans Facing the COVID-19 Pandemic. *Psychological Trauma, 12*(5), 455-456.

United States. Department of Health and Human Services.; Center for Mental Health Services (U.S.). (2004). Building bridges : mental health consumers and members of faith-based and community organizations in dialogue. Rockville, MD.