



# Hospitality Towards People with Mental Illness in the Church: a Cross-cultural Qualitative Study

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Accepted: 20 September 2021 / Published online: 29 October 2021

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## Abstract

Mental illness is a prevalent concern that affects Christian churches in North America in significant ways. Previous studies on the relationship between mental illness and the church have found that beliefs and practices within the church can contribute to stigma towards people with mental illness. Yet, the typical experience of people with mental illness who attend church has been found to be positive, suggesting that there are considerable resources within the church for supporting those who experience mental health problems. One such resource is the concept of hospitality, which promotes a sense of belonging for those with mental illness in the church. This qualitative study advances the construct of hospitality as a helpful paradigm for addressing mental health needs within the church, capturing perspectives and practices that are currently in place or seen as necessary by church attendees. The study methodology also emphasized the need to incorporate cultural considerations that are appropriate for the racial and ethnic make-up of particular churches. Semistructured focus group interviews were conducted with participants from eight churches that were either predominantly African American, Asian American, Latinx, or multi-ethnic. Findings resulting from content analysis of transcripts indicated that hospitality was a broadly helpful construct for addressing mental health concerns in the church, though some cultural differences existed in the understanding and application of hospitality. Both the interface of the findings with the existing scholarly literature and the relevance of findings for church leaders are discussed.

**Keywords** Mental health · Mental illness · Stigma · Hospitality · Culture · Christianity

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According to the Substance Abuse and Mental Health Services Administration (2020), one in five adults in the United States suffer from some form of mental illness. Among those who seek treatment for their mental illness, approximately 25% turn to a member of the clergy to get help (Wang et al., 2003). Pastors or priests continue to be contacted at a higher rate compared to psychiatrists by those who are religious and seeking help for mental health issues (Wang et al., 2003). Although religious affiliation is on a general decline in America, America still continues to be a religious nation, with over seven in ten persons affiliating with some type of religion and approximately 47% of Americans still maintaining church membership (Jones, 2021).

Given that churches and pastors operate as the first line of defense by providing support and resources for those with mental illness, there is a continual need to more comprehensively address mental health in churches (Chalfant et al., 1990; Lloyd & Waller, 2020). If properly resourced, churches, pastors, and lay leaders also provide a valuable contribution to public health in their local community by addressing mental health issues. Addressing mental health in North American churches remains essential for the church today. If left unaddressed, churches miss a much-needed opportunity to speak to the issue of suffering since many who suffer from mental health issues may never receive professional mental health care if the church does not provide guidance.

However, problems still persist in adequately addressing mental health needs within Christian churches. First, religious leaders want to help with mental health concerns but feel ill equipped (Chalfant et al., 1990). Many clergy do not know what classifies as mental illness and have not been adequately trained to provide professional mental health care (Farrell & Goebert, 2008). While clergy and faith leaders do feel a burden to address the emotional and mental health needs in the congregation, a large majority of pastors do not have a clear plan within their churches for helping those with mental illness (Abraham, 2014). Clergy often report feeling unequipped to support and lessen the stigma of those within their congregations who may be experiencing a mental illness (Collier & Swain, 2016). This experience can increase levels of stress (Bledsoe et al., 2011). However, the stress of addressing mental health can also be accompanied by a perception of opportunity. One study of Lutheran clergy found that they had moderate risk for compassion fatigue but also moderate potential for compassion satisfaction, indicating both the challenges and opportunities associated with engagement of mental health issues in the church (Jacobson et al., 2013).

A second problem is the complex needs of the families of those with a mental illness. In one study, Rogers et al. (2012) found that 27% of those attending Protestant churches reported having mental illness in their family. Moreover, those with mental illness in their family reported lower family strength and faith practices as well as twice as many stressors on average compared to families without mental illness. These families dealing with mental illness desired help from the church, and yet they reported that their faith community did not recognize or understand their needs. Rogers et al. conclude that families may be reluctant to talk about their difficulties with mental illness for fear of judgment.

Third, some of those attending American churches and congregations hold certain attitudes and theological beliefs that fail to promote a sense of belonging for those who have a mental health diagnosis. People living with mental illness can feel marginalized within the church if a sense of belonging is not actively fostered (Bishop, 2018; Swinton, 2015)<sup>1</sup>. If

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<sup>1</sup> John Swinton's work was very instrumental in our team's focus on hospitality, and defining some of the basic parameters of hospitality.

churches fail to provide a welcoming environment, those experiencing challenges in their mental health, whether acute or chronic, may not participate in church life within their community (Yong, 2011).

Fourth, churches in North America are culturally varied, with at times clear racial or ethnic identities. Martin Luther King Jr. often lamented that 11 o'clock on Sunday morning is the most segregated hour of the week, even within denominations with similar theologies (Burge, 2018). Thus, churches often have distinct cultural values and viewpoints that intersect with their denominational and theological identities. This diversity can foster a strong sense of belonging for those attending but can often make it challenging to develop broad strategic initiatives for welcoming people with mental illness into the church. Churches that consist predominantly of minority groups may view efforts to engage with mental illness very differently than predominantly White churches.

## **Aims of the study**

Christian theology provides unique perspectives regarding well-being, flourishing, and hospitality that can help deepen our understanding of certain psychological constructs (King & Whitney, 2015). In order for clergy to be equipped to meet the mental health needs of individuals and families, greater understanding is needed of how to address both theological and cultural nuances in a manner that is tailored to the unique characteristics of the local church. To this end, this study was designed to investigate culturally and theologically appropriate pathways towards greater hospitality in the church towards people with mental illness, along with possible pitfalls in pursuing this aim. The study design sought to identify potential resources within the church as well as existing barriers to hospitality within pastoral and church-wide practices. These resources and barriers could include beliefs, perspectives, practices, ministries, and broader approaches within churches that might hinder or facilitate hospitality towards people with mental illness.

To achieve a broader and comprehensive perspective that would meet the needs of stakeholders within the church, a qualitative methodology was utilized. The data analytic process moved from coding specific narrative statements to extrapolating particular themes that were present to identifying specific resources to utilize and barriers to overcome. The study methodology was selected so that findings would include theoretical and abstract components along with conclusions that would be actionable and concrete in regard to what churches could adopt and use. This allowed the study team to both identify novel perspectives and practices related to hospitality towards people with mental illness and explore divergence from established perspectives and recommendations in the research literature. The multidisciplinary team involved in this study utilized our collective understanding of church dynamics, cultural nuances, and stigma towards mental illness to review the findings for recommendations that would be best suited to meet the needs of diverse churches.

## **Literature review**

### **Linkages between faith and mental health**

Understanding the relationship between the church and mental health requires acknowledging the documented benefits of religiousness for mental health. There is a large body of

evidence demonstrating that active participation in religion is associated with improved mental health, especially in terms of depression, suicide, and substance use, with some evidence of its protection from dementia and stress-related disorders but no evidence of protection from schizophrenia and bipolar disorders (Bonelli & Koenig, 2013). Positive religious coping has been found to be associated with perceived growth following a trauma (Pargament et al., 2011), particularly the use of surrender (Lehmann & Steele, 2020). However, the relationship between religiousness and mental health should not be overstated. A meta-analysis looking at religiousness and depression in particular found that the strength of this relationship was quite modest,  $d = -0.18$  (Braam & Koenig, 2019). The effect was larger among psychiatric populations but smaller among younger populations and patients with medical illness.

At the same time, faith can sometimes pose risks for mental health. Religious struggle, or a felt experience of being punished or abandoned by God, is associated with greater depression (Braam & Koenig, 2019). Similarly, negative religious coping has been found to be strongly associated with symptoms of greater mental problems (Ano & Vasconcelles, 2005; Pargament et al., 2011). More broadly, the religious context can sometimes foster stereotypes, prejudice, and discrimination towards people with mental illness. For instance, religious fundamentalism has been found to be positively associated with stigmatizing attitudes towards people with mental illness among college students at a secular university who largely self-identified as Christian (Adams et al., 2018). These patterns can culminate in negative experiences for those with mental illness. In one sample, 30% of people with a mental disorder reported having had a negative experience within the church, including being abandoned, being accused of having a demon, or being told that sin was the cause of their illness (Stanford, 2007). In another sample, 41% of those with a serious mental illness were told that they did not have a mental disorder, especially those who attended church more than once a week and were from conservative and/or charismatic churches (Stanford & McAlister, 2008).

## Need for cultural nuance

As noted above, there is a need for greater nuance in regard to the relationship between faith communities, culture, and hospitality towards people with mental health conditions. Cultural differences affect the role of faith communities in addressing mental health. For instance, African American churches provide a significant coping resource for buffering the effects of discrimination and general anxiety, particularly for older African Americans (Nguyen, 2018; Okunroumu et al., 2016). Due to their social and economic marginalization, African Americans rely more heavily on their church for aid (Nguyen, 2018) and for meeting social and community needs (Robinson et al., 2018). Among these Black churches, African American clergy play an important role in delivering both professional mental health services and spiritual advising in their communities (Allen et al., 2010; Hays, 2015).

In a similar vein, Latinx individuals look to their churches for social, educational, and spiritual support (Caplan, 2019). Religious attendance may help explain the tendency of first-generation Latinx immigrants to function better than nonimmigrant Latinx, at least in regard to substance use (Moreno & Cardemil, 2018). Among Latinx individuals in faith-based settings, many reported that they would deny depression and mental health problems until they were suicidal or unable to function (Caplan, 2019), though they might be more likely if they felt understood or believed their problems to be biological in nature (Moreno & Cardemil, 2013).

Asian American churches are perhaps distinctive in that they are often used for cultural preservation, resulting in intertwined religious and ethnic identities that have been termed “ethnoreligious” (Park & Dizon, 2018). Religious communities may thus offer opportunities for better cultural understanding and ethnic identity development. Yet, there is significant cultural variation across Asian American ethnic groups (Paik et al., 2014). In Korean American churches, pastors are supportive of greater mental health resources within their churches and believe that structural changes are needed to bring this about (Cheon et al., 2016).

These differences within ethnic churches may reflect broader cultural values. There are known differences in mental illness stigma across nations and cultures (Pescosolido et al., 2008). African American students have been found to have higher mental illness stigma than Latinx college students (DeFreitas et al., 2018). Compared to European Americans, Asian American college students have higher mental health stigma and more negative attitudes about help-seeking (Masuda & Boone, 2011). Attitudes about seeking help among Asian Americans have been found to be related to a preference for self-control (Han & Pong, 2015) and a tendency towards self-concealment (Masuda & Boone, 2011). However, mental illness stigma has been seen in every culture in which it has been studied (Koschorke et al., 2017).

## Perspectives on mental illness

**Spiritual etiologies** Part of the church’s response to mental health challenges is to provide an explanatory framework for the underlying causes of mental illness. Christians often incorporate spiritual and theological concepts into their understanding of mental illness. There exists a spectrum of beliefs among clergy in regard to the causes of emotional problems, ranging from viewing such problems as the result of demonic oppression or ungodliness to explicitly denying demonic involvement (Payne & Hays, 2016). Christians often attribute mental illness to sin or other spiritual factors, such as demons, lack of prayer, or need for spiritual care (Hartog & Gow, 2005; Wesselmann & Graziano, 2010). Christian authors of best-selling books tend to ascribe mental illness to entirely spiritual factors, such as demonic influence and failure as a Christian, and to prescribe entirely religious interventions such as trusting God, engaging in religious practices, and utilizing one’s will (Webb et al., 2008).

One important concern is how these beliefs about the causes of mental illness can affect the church’s response to people with mental illness. Some researchers have expressed significant concerns about these beliefs and encouraged replacing these beliefs with scientific understandings of mental illness, expressing concern that spiritual views of mental illness might increase stigma and prejudice, decrease openness about mental health struggles, hinder treatment seeking, increase attempts at self-management of symptoms, and even have destructive effects on people’s faith (Webb et al., 2008). Congruent with this concern, one study found that beliefs about the etiology of mental illness that attributed it to sin or to other spiritually oriented causes were found to be associated with more negative attitudes towards mental illness and prejudice towards people with depression and schizophrenia (Wesselmann & Graziano, 2010). Although this might suggest that spiritual beliefs about etiology are the cause of stigma and prejudice towards people with mental illness, the lack of a validated measure of religious beliefs and failure to control for relevant confounding variables suggest that such a conclusion is premature.

In fact, there is a possibility that spiritual etiological beliefs about mental illness might not be as detrimental as some have argued. Some research demonstrates that there might be concomitant benefits to framing mental health issues as spiritual problems that, for some, balance out any harms these views may create. In one study, attributing mental illness to sin or other spiritually oriented causes was associated only with increased spiritual support and was not associated with differences in support for secular counselors or other forms of support (Wesselmann et al., 2015). Another study found that 94% of evangelicals surveyed supported secular interventions such as therapy and medications (Lloyd & Waller, 2020). This complexity in the relationship between spiritual and biological/psychological beliefs is less intuitive but was also noted by Mathews (2008). This growing area of research seems to suggest that spiritual etiological beliefs do not strongly inhibit pursuit of secular interventions, even if they can cause some hindrances. According to Lloyd and Waller (2020), attempts to eradicate spiritual views of mental illness may not be necessary and may actually hinder efforts to support people with mental illness. Instead, Lloyd and Waller (2020) advocate for a “both/and” rather than an “either/or” approach to spiritual and psychological understandings of mental illness.

**Views related to belonging and hospitality** Although spiritual etiological beliefs about mental illness are important to understand, Christianity offers extensive theological perspectives on the treatment of people living with mental illness and on mental health in general. These theological resources from within the Christian tradition can be used to help address mental illness within the church. One key theme within the Christian community is belonging. Rather than merely including people with mental illness, fostering a sense of belonging is necessary in order to ensure that people with mental illness are not marginalized (Bishop, 2018). Swinton (2012) argues forcefully for surpassing mere inclusion of those living with disabilities and instead demonstrating deep love that fosters a sense of belonging in the faith community. This emphasis on belonging is rooted in Scripture as Jesus’ care for those who are different or unwanted is at the core of the gospel (Swinton, 2015). This sense of belonging can be the result of hospitality that is modeled after the practices of Jesus.

Creating a sense of belonging within the church involves thinking more positively about people with mental illness. Christianity offers numerous perspectives that might be able to foster positive attitudes and behaviors towards people with mental illness. Webb (2012) outlined three key ideas: heroism in frailty, freedom in finitude, and the stranger in our midst. The first point made by Webb is that Christianity honors those who exhibit heroic courage in the face of their struggles, such as Moses and Paul but also exemplified by Christ on the cross. Abraham (2014) expanded upon this theme, arguing that engaging people with mental illness demands the courage to identify with the suffering of those with mental illness, the courage to humanize people with mental illness by befriending them, and then the ability to recognize the courage of those who live with mental illness. Webb (2012) argues that the Scriptures point to God’s concern for the estranged; God even entered into the world as a stranger on our behalf.

Yet, rather than simply viewing mental illness as a hardship to be overcome, it is important to also recognize that mental health challenges offer opportunities for deeper spirituality. Those who suffer from mental illness can take comfort in God’s own ability to suffer, including God’s willingness to die on a cross (Scrutton, 2015). Christians can experience comfort in knowing God understands their pain. Moreover, mental illness might offer

the opportunity to help one to live faithfully, be compassionate, and appreciate beauty (Scrutton, 2016).

Finally, navigating perspectives on mental illness within Christian communities also requires appreciating the intersecting cultural and denominational differences in etiological and theological beliefs related to the treatment of people with mental illness. For instance, Latinx individuals in faith-based settings tended to acknowledge some biomedical aspects of mental illness but often also identified spiritual causes such as lack of faith or prayer, demonic influence, or sins of the parents (Caplan, 2019). Similarly, Pentecostals held complex views of the causes of depression but generally viewed faith as the best way to overcome depression (Trice & Bjorck, 2006). Lloyd and Waller (2020) have argued that engagement with mental illness ought to be culturally and spiritually sensitive as people engage in meaning making that often incorporates both spiritual and psychological understandings of mental illness.

### Practices in response to mental illness

Engagement with mental health requires active *practices* and not mere *perspectives*. The church has a responsibility to be a voice for the voiceless by advocating for those with mental illness and educating others in regard to their conditions (Bishop, 2018). Here, these practices are grouped into two types: church-based practices and professional referrals.

**Church-based practices and ministries** Creating hospitality for people with mental illness within the church can involve several layers. Most broadly, the church model can be reimagined to better accommodate people with mental illness. Bishop (2018) argued that church ought to be designed for people with mental illness by incorporating different models of church such as traditional churches, recovery-oriented churches, house churches, and community-serving churches and blending together their strengths (Bishop, 2018). Doing so can require creativity but can foster a structure that conveys that the church welcomes those dealing with mental health challenges.

Churches can also provide appropriate accommodations for those with mental illness. Churches have often failed to keep up with providing appropriate accommodations to people with disabilities (Yong, 2011), but many churches do have sign language interpretation, braille hymnals, and wheelchair-accessible entrances. However, churches have not done as much to accommodate, for instance, the sensory experiences of people with autism or the situational needs of those with social anxiety disorder or panic disorder. Such accommodations can communicate to individuals with mental disorders and their families that they are welcome in that church community.

Ministries specific for people with mental illness or mental health challenges could also be offered. Rogers and Stanford (2015) developed a resource for churches called Living Grace Groups that incorporates principles of nonreligious peer-support models, including psychoeducation, relapse prevention, coping, social support, and mentorship but also promotes the utilization of positive religious resources. Living Grace Groups have been associated with significantly improved religiousness and spirituality as well as decreases in psychiatric symptoms (Rogers & Stanford, 2015). Several mental health programs have been implemented in African American churches to address disparities in mental health care, though they remain somewhat limited (Hankerson & Weissman, 2012). Churches can offer workshops and seminars relevant to mental health that can educate the congregation,

empower those with mental illness, and encourage family members and friends of those dealing with mental health problems.

Yet, ministry should not just be *to* people with mental illness but should also be *with* them (Yong, 2011). Swinton (2015) argued that Jesus modeled a type of hospitality where he often alternated between being a guest and being a host. Swinton cautioned against the attitude that people with mental illness should only be seen as guests. There is an empowering dignity to being a host that can bring honor to those experiencing mental illness. Merely including people with mental illness is a thin form of hospitality, whereas thick forms of hospitality go much further (Swinton, 2012). To foster this sense of belonging and honor, churches can welcome people with mental illness into their ministries. Those struggling with mental health challenges should have opportunities to participate in discipleship, leadership, and service rather than having to wait until they recover, and these ministries should not look drastically different for the person with mental illness (Bishop, 2018). Furthermore, Christians can befriend people with mental illness and invite them into their communities to demonstrate that they truly belong (Swinton, 2012).

**Professional referrals** The other major practice that churches can demonstrate is effective referrals by clergy and church staff to professional resources. The research on this topic has been mixed and suggests that there may be regional and cultural differences in these practices. In a California sample, clergy preferred referrals to counseling centers over other types of community resources (Bledsoe et al., 2011). However, in a Texas sample, clergy reported rarely referring to mental health professionals (Polson & Rogers, 2007). There may also be racial or cultural differences as collaborations with mental health providers have been noted to be important for Black churches (Okunroumu et al., 2016), whereas Asian American clergy tend to refer first to general practitioners who then may refer persons on to mental health specialists (Yamada et al., 2012).

Clergy's referral practices can depend on their secular education (Payne, 2014) or their theological education. In a survey of master of divinity programs, only 34% provided a course on counseling or mental health, suggesting that clergy may need further training and support on mental health awareness and appropriate interventions (Ross & Stanford, 2014). Yet, clergy feel strongly that they have a role to play in responding to mental health concerns and that mental health should not be relegated entirely to the professional sphere (Payne & Hays, 2016).

Finally, it should be noted that a strict dichotomy between church and professional settings might not be helpful. Religious individuals prefer to incorporate religion and spirituality into their mental health treatment (Bryant-Davis & Wong, 2013), and inclusion of religion/spirituality in treatment seems to improve outcomes (de Mamani et al., 2010; Hefti, 2011). For this reason, linkages with professional services that are appropriate for Christians should be prioritized.

## Research questions

The literature reviewed above highlighted two sets of questions that this study set out to address:



1. What do church members see as helpful perspectives and viewpoints on hospitality towards people with mental illness? What perspectives and viewpoints do church members cite as a barrier to hospitality? How do these perspectives vary based upon church cultures? How do these perspectives converge with, or diverge from, the research literature?
2. What do church members note as helpful church practices, ministries, and responses to mental illness, including ministries that exist and those that may be needed? What church practices, ministries, and responses to mental illness do church members believe could be a barrier to hospitality? How do these practices and responses to mental illness vary based upon church cultures? How do these perspectives converge with, or diverge from, the research literature?

## Method

### Sample selection

A purposive sample of churches was recruited to participate in focus groups. Between November 2019 and May 2020, the research team screened 13 churches in Southern California for eligibility. Eight churches were selected after phone screening and scheduling. The day and time for each focus group was selected with input from the church leader, who was aware of conflicting events at the church. The sample was purposive in that the inclusion criteria included multi-ethnic, primarily Black, primarily Asian, and primarily Latinx churches. The use of multi-ethnic, rather than primarily Caucasian, churches was appropriate given that rising diversity in America has resulted in fewer homogeneously Caucasian churches in the region. The multi-ethnic churches were also selected for being exemplars in regard to mental health ministries. The goal was to have church-based focus groups where family members or friends of people with mental illness would be included.

After the church leader gave host approval for a focus group to take place at their church, researchers collaborated with church staff to determine how recruitment would work best at the church. Participants were recruited via use of fliers, recruitment videos, PowerPoint presentations, emails, and phone calls. To qualify for the study, interested church members signed up through Google Forms, and these volunteers later participated in a confidential phone screening to determine eligibility. Church members with serious mental illness were excluded from participation due to concerns about confidentiality and to facilitate open discussion.

### Procedure

Approval was obtained from the Azusa Pacific University Institutional Review Board prior to conducting the study. Participants in each focus group provided informed consent either in hard copy or digitally. Potential participants in each church focus group were informed that the purpose of the study was to learn how churches are showing hospitality towards people living with mental illness. Church members from each of the eight congregations were invited to a focus group lasting approximately 90–120 minutes. Prior to COVID-19, the focus groups were held in person at the church, and after COVID-19 quarantines began the focus groups were conducted via Zoom.

Two to three researchers were present at each focus group and led the discussion based on a semistructured, open-ended questionnaire. Prior to the discussion, participants were provided with a dinner and individually completed a demographic survey. Participants were instructed to share openly, with group consensus to maintain confidentiality, and were encouraged to respond to comments made by other participants. Participants received an honorarium of ten dollars in the form of an Amazon or Starbucks gift card after participation in a focus group. This gift card was either handed to participants, for in-person groups, or emailed, for Zoom focus groups.

### **Semistructured instrument**

Each focus group was led by asking semistructured, open-ended questions. The questions that were asked in each focus group were:

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?
6. Do you know people with mental illness who come to your church? What kinds of problems do they have?
7. When someone has mental illness and comes to your church, what do you think their experience is like?
8. Do you think it is important to address mental health in the church, and if so, 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 who are encountering distress or suffering?

In addition, probes were used to explore cultural views of mental illness that might help or hinder people seeking help with mental illness at each church.

### **Data coding and analysis**

Each focus group interview was transcribed verbatim through the use of transcribers at Rev (<https://www.rev.com/>). Qualitative content analysis was used to explore the mental health views of church focus group attendees (Kolbe & Burnett, 1991). A priori coding took place (Stemler, 2001) based on a detailed literature search identifying themes pre-

viously mentioned by other researchers regarding mental health in the church. However, the emergence of new themes was also allowed (Stemler, 2001). Coding categories were revised by combining and adding new categories as new themes emerged from the text.

## Rigor

Coding categories were revised by combining and adding new categories as new themes emerged from the text. To increase qualitative standards of rigor, each transcript was separately reviewed by two researchers to determine if the categories that emerged held together (Bernard, 2018). We triangulated our approach to the data by using three tools—coding through the use of Dedoose, coding through the use of MAXQDA 2000, and coding by hand. Transcripts were coded separately and then were compared at three time points to achieve consensus and to increase trustworthiness (Creswell & Miller, 2000). We kept detailed audit trails—code memos, theory memos, and memos of our own reactions and observations. Themes emerged through the coding and evaluation process. Pseudonyms were used to protect participant confidentiality.

## Findings

The qualitative content analysis of the focus group transcripts addressed the two sets of research questions described above: (1) perspectives and viewpoints and (2) church practices, ministries, and responses to mental illness within the church. The analytic process worked to triangulate both strengths and barriers for each research question as well as the similarities and differences between the racial/ethnic groups. The final question within each research question set (i.e., the alignment of focus group participants' views and the research literature) is not addressed in this section but is instead addressed in the discussion. Below is a summary of the findings in relation to the research questions for this study.

### Perspectives and viewpoints on hospitality towards people with mental illness

Shared perceptions of helpful perspectives on hospitality towards people with mental illness were reported across all church focus groups. Such perspectives on hospitality were associated with how participants related to people with mental illness and viewed their church experience, participants' attitudes towards mental illness and the role of the church, and participants' suggestions of Scripture references that would assist with hospitality towards those with mental illness.

One theme that emerged across all groups was the similarities in what hospitality actually meant for the church. To act in a way that was hospitable to people with mental illness meant that other church members noticed those with mental health needs, recognized them as persons, and acted lovingly towards them. This acknowledgment of the person was seen as a gesture of compassion and a display of love of others. For some of the groups, hospitality included strong themes of acceptance and a sense of belonging, which participants in both the multi-ethnic and Latinx churches said would involve inviting and welcoming the person with mental illness to participate in the life of the church. Stress was placed on this welcoming and sense of belonging being done no matter who the person was. A Black church participant stated that hospitality especially included a respectful, nonjudgmental

stance towards those with mental illness. Asian American church focus group members defined hospitality as acting with sensitivity, awareness, patience, selflessness, and grace.

While themes of belonging and love were consistent throughout the groups, some understandings of hospitality were nuanced even more. For instance, according to some focus group participants, hospitality includes persistence and spiritual discernment. Persistence is necessary since others might not immediately respond positively to hospitable gestures. According to these understandings, hospitality included themes of not giving up and of continually turning towards someone in a loving manner. Hospitality involved listening, prayer, and adapting one's response in love to the person with mental illness. In another instance, hospitality was seen as a task that required guidance by the Holy Spirit, such that turning to someone in hospitality needed to be "Spirit-led."

Establishing hospitality towards those with mental illness moved beyond individual church members reaching out in love to include the involvement of the church. Here, themes of hospitality related to the role of the church playing a central role in normalizing mental illness. These themes repeatedly surfaced in Asian American and multi-ethnic church focus groups. Here, the church played a central role in helping to influence other church members to be more open about their struggles and to know they were not alone. A Latinx participant stated that the church had an important role because the church had "a heart or spirit of hospitality" and was the "salt and light" of the world. Black church participants viewed the church as a "balancer" that could counteract feelings of instability and insecurity for individuals and families suffering from mental illness. Another participant expressed the belief that some people had hospitality as a spiritual gift and might be particularly suited for certain outreach tasks, whereas other people could be trained for hospitality.

According to focus group members, hospitality could engender a positive experience in people experiencing mental health challenges. The association of hospitality with joyful experiences in one's relationship with Christ emerged from a multi-ethnic church focus group. A member in a Latinx church focus group associated hospitality with rest and healing of the body, mind, and soul for those suffering from a mental illness, similar to what one might experience at a five-star hotel or a hospital.

### **Barriers to hospitality within the church**

While focus group members agreed that hospitality was vital for the church, barriers still exist within the church that make it difficult to show hospitality towards people with mental illness. Reported barriers included (1) theological perspectives that could actually exclude or lead to further stigmatization, (2) advocating for only spiritual solutions to mental health while ignoring professional help, (3) individualistic approaches to Christian spirituality that discouraged seeking help, and (4) stigmatization of seeking professional help because this was viewed as indicating a lack of spiritual strength.

For instance, some participants mentioned that Scripture taught in the churches has often been misunderstood as burdensome and problematic by those who have a mental illness, thus causing the ministries and congregation to not be inclusive of them in Bible studies. Asian American focus group members were keenly aware of churches that preached or taught that reading Scripture and praying should be sufficient for dealing with mental health issues. Members of all focus groups indicated that they were taught to be strong and not openly talk with others or seek professional help for their struggles (these things were considered "taboo"). Instead, they were taught to only talk to Jesus and were told

that “everything will be fine.” In some cases, churches believed that seeking professional help means you are weak, you cannot deal with your own problems, or you do not believe in God. Another member from one of the Asian American groups added that it is more important for the church to be mindful of how the Bible is being used when discussing mental health issues than merely talking about or quoting the Bible without much consideration of what individuals with mental illness experience. In Black churches, it was reported that due to the connection of mental illness with “demonic possession,” the common response towards those with a mental illness was to pray for the person so the evil spirit would leave them. Some African American focus group participants indicated that Black culture discouraged disclosing family secrets and getting help from those outside of the household, such as in cases of molestation and domestic violence.

Other characteristics created further barriers to a hospitality-based perspective. When examining the role of the church, there was a tension between the church’s role and professional treatment at some churches. For example, some focus group members were aware that certain Christians believe that professional treatment is limited compared with spiritual healing. Others believe that psychological counseling is not in God’s will. Similarly, some participants expressed resistance to medications—especially medications that deal with emotional rather than physical issues. The underlying idea is that medications prescribed by a doctor for physical ailments were seen as more acceptable than medications prescribed by psychiatrists to aid in mental health.

Additionally, there is pressure in some churches to put on a “church face,” which means giving the impression that everything is all right, or to rely on Scripture to rebuke emotional problems. Consequently, participants identified as a barrier to hospitality people at church who “come across as having it all together.” Feelings of superiority (Pharisee-like behavior) can keep some church members from having compassion for those who struggle with mental illness in the church. Some churches are uncomfortable with depression, for instance; there is a perception that if you are depressed, you are not Christian or led by the Spirit. One participant encouraged directly speaking to this idea, saying, “We have to really begin pretty fundamentally within the church to say we can still be very broken and spiritually be very firm in our walk and to kind of reconcile these two.” Moreover, Scripture can sometimes be used on a surface level to give a quick word to another on what they should be feeling rather than addressing what they are actually feeling; one participant expressed, “Sometimes Scripture verses can be a burden on people.”

Demands upon time and feelings of fear were further barriers to hospitality. Some participants worried about the investment of time and energy that needed to be made. In these cases, the potential to feel drained, overwhelmed, burdened, or burned out in response to those who are mentally ill was mentioned as inhibiting church members from reaching out or becoming more available. Other church members were fearful about physical violence by people with mental health issues towards someone trying to help. Being afraid also took the form of fear of potentially making a problem worse by saying the wrong thing and bringing a person’s mood down rather than up. Fears also manifested itself in concern about lacking knowledge about treatment or feeling unequipped in how to interact with those who had mental illness. There were also fears expressed regarding how to deal with more serious issues, such as suicide, and participants’ awareness of the lack of structure or support within the church to help those with more severe mental illness.

## Intersections of stigma, faith, and culture

Across all ethnic and cultural groups represented, stigma played a significant role in inhibiting interaction with individuals with mental illness within the church. In general, the degree of stigma towards those with mental illness exists on a continuum (Ashforth, 2019); however, stigma is potentially more serious when stigma exists within both cultural and theological constructs.

In the Asian American focus groups, the theme of stigma in the forms of cultural and family shame was discussed; mental illness was often considered shameful to share with others and was kept within the family. Also, there was the belief that something is bad within the sufferer or that God was punishing them. In the Black community, people feared the stigmatized label of “crazy” being placed upon them if they had mental health issues. Focus group members from Black churches discussed the stigma about taking medication, with some even mentioning that faith leaders were skeptical about the role of medication in healing. Similarly, in Latinx churches it was mentioned that, within Latinx culture, framing problems as mental illness might not be well received. Instead of wide recognition of the toll that mental health might take, it was more acceptable to discuss problems as related to life circumstances, family, emotions, and drugs rather than as mental health issues. Latinx churches also expressed a belief in spiritual attacks (rather than a long-term mental health diagnosis) coming in the form of *ataque de nervios*. *Ataque de nervios* (“attack of nerves”) is classified as a cultural diagnosis among individuals of Latinx descent (American Psychiatric Association, 2013). Symptoms are characterized by acute anxiety, anger, or grief, screaming and shouting uncontrollably, and an overall sense of being out of control (American Psychiatric Association, 2013).

In sum, the shame and stigma associated with mental health differences keep people from getting help. Thus, some in the church are silent about their struggles, and the stigma of mental illness keeps people from disclosing what they may be dealing with.

## Church practices, ministries, and responses to mental illness needed for hospitality

Supportive church practices and responses to mental illness are an extension of perspectives and viewpoints previously mentioned that involve welcoming, belonging, and love. Without such favorable perspectives, some churches do not directly respond to mental illness or talk about mental illness in an honest way. Many of the participants agreed that the church pulpit may be a starting place for mental health awareness and education. Responses across all focus groups were similar in that some pastors are open to discussing mental health topics in their Sunday sermons and incorporating programs within their ministries while others do not address the topic at all due to stigmatized cultural beliefs about mental illness. Some churches may not give people with mental illness a platform to share or are unwilling to listen to their needs. Honoring people’s privacy, confidentiality, and trust within the congregation by not sharing sensitive information and creating safe spaces was highlighted by Black church members (“what happens in the house stays in the house”). Both Latinx and Black focus groups suggested that personal testimony and more support might increase people’s awareness of mental health issues and would encourage them to look for help. One participant from a Black church even noted that the church could advocate for people with mental illness as it could help reduce encounters with police that could pose a risk.

Another major theme across all cultures regarding important church practices was the great need for mental health awareness and education among church members and the pastoral staff. Many in the church have misconceptions about mental illness and do not know how and when to help in a safe manner. Increased mental health training and education on mental illness and treatment, including use of medication, were reported as necessary. With such education, lay leader and professional roles would be further clarified so that lay leaders would understand when referrals would be appropriate instead of providing inappropriate responses and solutions to members, causing greater harm or members to leave the church. Intentional support and guidance for pastoral staff and leaders were also highlighted to prevent burnout and to set healthy boundaries for proper self-care when providing hospitality to individuals and families dealing with mental illness. Leadership training and spiritual equipping were also noted as essential in preparing pastoral staff to work with individuals and families with mental illness.

Participants also shared thoughts about what outward demonstrations of hospitality would look like. Several participants conveyed that hospitality often included nonverbal elements such as eye contact, touch, and tone of voice. A Latinx member mentioned the importance of being mindful of one's intonation and eye contact when relating to those with a mental illness. Although appropriate touching or hugging of people with mental illness was generally seen as helpful, some focus group participants pointed out that it was important to be sensitive to how touch might affect a person with mental illness.

Another helpful practice that was identified was providing people with mental illness opportunities to serve within the church. Focus group members at one multi-ethnic church mentioned the roles played by a man with a developmental disorder and a woman with cognitive difficulties related to mental illness, including overseeing the coffee bar, setting up for church potlucks, and other tasks. Yet, it was not clear whether these opportunities for people with mental illness were consistently being offered at the other churches. These represent opportunities for churches to include those with mental illness by incorporating them into the life of the church and allowing congregants to get to know them outside of the label of mental illness.

Culturally specific mental health programs, community resources, and support were also identified as significant but lacking in churches. Programs, seminars, and support groups within the church that attend to generational differences (older generations in Asian American churches) and particular age groups and gender (men in Latinx churches) that are culturally sensitive were identified as essential to extending hospitality to those with mental illness. Church-funded support for mental illness treatment was discussed as a helpful way to extend hospitality. Caregiver support was also mentioned by Black focus groups members as another way to extend hospitality and care. Broadening mental health awareness to the entire church congregation would increase relevance and understanding to the general community. Regarding new programs in larger churches, the challenges of proper follow-up with people with a mental illness was also noted in one of the focus groups. This highlighted the need for an ongoing program and structure within the church so that those with mental illness could keep experiencing this hospitality. Exploring new ways to share and advertise the mental health programs and ministries more widely was reported as lacking. Additionally, mental health community resources addressing the unique needs of different cultural groups were mentioned as important factors to remove obstacles to seeking help and increasing access to care. The Black and multi-ethnic church focus groups specifically mentioned acknowledging and developing external programs for homeless people.

Finally, all focus groups provided suggestions for ways that lay church members without professional expertise can extend hospitality to those with mental illness. Listening with

compassion and a “wise heart” was one of the most commonly reported ways to extend hospitality, along with prayer support. Despite the barriers to hospitality that exist, straightforward ways of extending hospitality were highlighted, such as simply being a friend and offering spiritual encouragement. A Latinx member discussed how peer mentoring and support by those who had already received help and experienced recovery could be extremely helpful. Other simple acts, such as smiling and kindness, patting a person on their back, or just offering food might transform someone’s life and help church members change from feeling helpless to hopeful in helping those with mental illness.

## Discussion

The complex relationship between the spiritual understandings of mental illness and responses to mental illness observed in this study suggests that perspectives on mental illness should be understood within both the theological and ethnic/cultural context of individual churches or denominations. The findings in the study support the position advanced by Lloyd and Waller (2020) that a both/and rather than an either/or perspective on the intersection of spirituality and science should inform one’s view of mental health within the church. Although the findings are based upon a small number of focus groups within Southern California and thus may not be directly representative of churches in other regions, the research offers a crucial first step in the research on the intersection of culture and mental illness within the North American church.

The findings from this study provide a striking account of the broad-ranging resources that the church has for safeguarding mental health and providing care for those experiencing mental disorders, even if the church, at times, is falling short of its own aspirations. There were ostensibly broad commonalities across the represented racial groups, along with a few distinct aspects, in regard to perspectives and practices related to mental health hospitality. The focus groups collectively discussed similar concerns regarding shame and stigma towards mental illness, along with the considerable need for understanding, education, resources, and support for mental health within the churches. The subsequent sections cull down the perspectives and practices that cut across racial divides, discuss the cultural differences that were identified, and then address how the views expressed by the focus group participants coalesce with the current research literature. Finally, the implications of the study findings for faith leaders in the North American church are discussed.

### Perspectives for fostering hospitality

The findings indicated that hospitality was a helpful concept across racial/ethnic cultures for positive responses to people with mental illness. Focus group participants defined hospitality as welcoming people into a community where they could belong and could experience healing. Hospitality involves seeing people with mental illness as equals and acknowledging their personhood by interacting respectfully, demonstrating sensitivity to their mental status, and being nonjudgmental. Normalizing struggles with mental health, rather than “wearing a mask” that hides one’s real problems, is important for hospitality in that it facilitates a sense of belonging.

Participants were unified in sharing that they saw hospitality towards people with mental illness as worth the challenges it might bring. They believed that hospitality was one of



the church's essential tasks because it involved "caring for souls," which they saw as the crux for why the church exists. Underlying this caring response was the hope of fostering a sense of safety within the church. Doing so would allow the church to restore a sense of balance to those struggling with their mental health. When demonstrated effectively, hospitality was thought to bring about an experience of joy and love at church for all involved, not just those receiving the hospitality.

To promote hospitality, churches ought to address problematic spiritual views on mental illness. According to the focus group participants, the church could fail to show hospitality for several reasons that were explicitly grounded in spiritual beliefs. One major barrier was the perception that people with mental illness were not Christian, were not led by the Spirit, or were possessed by demons. The focus group participants did not seem to agree with these sentiments, but they reported awareness of these beliefs within their respective churches. Related to this was the idea that people with mental illness lacked strength, which could include strength of faith but also mental toughness. Participants argued that the emphasis on demonstrating strength seemed to engender opposition to medication and professional therapy. The focus groups expressed that these perceptions as a whole made it difficult for people to be honest and open about their mental health challenges.

Churches can also decrease stigma by providing a coherent theological understanding of mental illness, especially given that the view that mental illness is primarily caused by sin and demonic influence may not be consistent with Scripture (Webb, 2012). Such views might highlight the potential to promote spiritual and personal growth and could be particularly helpful for some theologically conservative Christians. For instance, Armentrout (2004) developed a conceptualization of depression as a "heart cry" that indicates a real or felt separation from God has occurred. From this perspective, a depressive response can lead to restoration of one's relationship with God. Many Christians, including those in this study, might value this sort of understanding of mental illness because it might serve as motivation for spiritual growth amidst their mental health challenges.

Yet, beyond an exclusively spiritual view, leveraging the resources of faith communities effectively for addressing mental illness and mental health might require holistic views of mental illness. Among the study participants, spiritual views coexisted with scientific and professional views that recognize the role of diagnoses and professional treatment. Advancing hospitality towards people with mental illness might entail integrating these spiritual and scientific views of mental illness in a way that church leaders and members could easily understand. In this vein, Scrutton (2015) argued that both the moralizing and medicalizing views of mental illness are incomplete and suggests that viewing mental illness as the result of societal sin, such as poverty, discrimination, and violence, might be more helpful and would reflect both Christian and professional views.

Other barriers to showing hospitality seemed less directly spiritual. Several focus group participants reported fear of the demands on their time and energy as a barrier to showing hospitality towards people with mental illness, with a couple of these providing personal examples of when this had occurred. Participants noted that many people are unsure how to talk to a person with mental illness or worry about saying "the wrong thing," and avoidance of this awkwardness leads them to remain distant. In fact, there was a concern that talking with people about their mental health could potentially make their condition worse. This uncertainty about how to communicate was attributed to a lack of knowledge about mental health. Focus group participants expressed that training on mental health could be especially helpful as the knowledge component was lacking for many in the church.

Lastly, several participants mentioned the potential of violence by people with mental illness as a concern that hinders hospitality. These participants brought up the possibility of gun violence and suggested safety measures, including having armed ushers. Although those who raised these concerns did not express this as a reason to be less hospitable, it would seem plausible that this fear could interfere with a hospitable response to people with mental illness.

## Hospitality practices

The second research question was about the practices, ministries, and responses in the church that demonstrated hospitality towards people with mental illness. This research question was about behaviors and processes, in contrast to the previous research question addressing perspectives and ideas. The participants reported several practices that they recommended to be implemented. In some cases, participants shared practices that were currently in place at their church. In other circumstances, the discussion was on practices that were needed.

One suggestion common across focus groups was for the pastor to speak about mental illness from the pulpit. Some of those who mentioned this idea suggested that pastors could share about their own mental health struggles as a means of normalizing these sorts of problems and modeling open disclosure. Another approach could involve people with mental health challenges sharing their personal testimony during services.

Most focus groups noted the need for training and education on mental illness, including specialized training for church leaders but also for the church more broadly. The education could include general information on types of disorders, treatment options of therapy and medication, and suicide awareness and prevention.

Another ministry that was noted frequently in the focus groups was the role of small groups in providing a venue for disclosure of mental health challenges, support for those with mental illness, and gatekeeping to identify mental or emotional problems that were more severe. Some participants emphatically expressed a desire for caregiver support as those who care for people with mental illness have unique needs that can go unmet. However, the role of confidentiality within small groups, and in general the disclosure of mental health concerns, was paramount in the church's response, especially in small group settings. Churches that fail to keep confidentiality were identified as unsafe places for disclosure of mental health concerns. Violations of confidentiality lead people to withhold their emotional struggles from those they interact with in the church. Thus, building a culture of trust and appropriate confidentiality is paramount in the church's response to mental illness.

The church's response to mental illness can also include linkages to professional services in the community, preferably with Christian resources. Some focus group members reported that their church had a professional counseling ministry or worked extensively with a counseling center that they had partnered with for mental health services. Participants spoke highly of these sorts of resources because of the accessibility that was provided.

Lastly, including people with mental illness in service activities would likely provide a sense of empowerment. Several participants discussed specific instances where a person with mental illness in their church had taken on opportunities to serve in relatively routine tasks, such as setting up for church events, or in a more formal service role. Focus group members at one church reported honoring an older man with special needs

who had served at the coffee bar for several decades by giving him a plaque and naming the coffee bar after him.

### **Impact of racial/cultural diversity**

As noted above, the findings pointed to considerable overlap in the resources and barriers to hospitality that were identified. This may be the result of stigma towards mental illness being prevalent across a broad array of cultures (Koschorke et al., 2017). Yet, this point should not be overstated because the findings did include distinctions in the perspectives and responses that our research team attributed to cultural factors.

When considering responses to mental health problems in Asian American churches, focus group members from Asian American churches frequently emphasized the need for training and education. This preference for educational approaches to mental illness might reflect underlying values for educational achievement that are common in Asian American culture, though there is considerable diversity among various subpopulations (Paik et al., 2014). The focus group participants also more frequently encouraged professional treatment than the African American or Latinx church focus groups.

Although there was only a single focus group within a Latinx church, its participants frequently mentioned the role of families when discussing mental health that was thought to be consistent with the strong family orientation in this culture. For this focus group, the impact on the family was a litmus test for the severity of the mental health problem. Yet, the family was also potentially a resource for addressing mental health problems if initial skepticism about the problem being related to mental health could be overcome. In fact, it seemed that framing behavioral or emotional problems as mental illness might not be helpful among the Latinx community due to significant skepticism about the validity of the diagnoses. The sharing of personal testimonies was seen as valuable for overcoming the cultural stigma. However, these conclusions are especially tentative and may more strongly represent Mexican American perspectives than the Latinx faith community more broadly.

Within the African American church focus groups, there were several distinctives that seemed related to cultural factors. Participants expressed fear of being labeled “crazy” as a key barrier, with this fear seeming to be more pronounced than in other groups. Taking psychotropic medication was linked to this label, which meant that African American individuals might be discouraged from following prescribed treatment plans out of a desire to avoid being labeled. Moreover, the notion of demonic possession was more strongly linked with mental illness among African American focus group participants than in other focus groups. Finally, there was a cultural norm that it was inappropriate to disclose family secrets that discouraged open sharing of mental health problems, especially if they were consequent to family abuse, domestic violence, or molestation.

The African American focus groups also stressed several responses to mental health concerns in ways that were distinct from other focus groups. One response that was emphasized more strongly in these focus groups was the importance of focusing on the homeless, although participants from a multi-ethnic church in an urban area also mentioned this concern. Sharing of one’s personal testimony was similarly highlighted by the focus group participants from the African American churches, though it was also noted by other groups. Finally, participants from the African American churches pointed

out the importance of advocacy for people with mental illness, especially in regard to encounters with the police, which was not noted by other focus groups.

Finally, multi-ethnic churches were distinct from churches that had a predominant ethnic identity in several ways. The most obvious was that focus group participants from ethnically identified churches recognized common experiences related to their culture, whereas multi-ethnic churches did not have that common cultural identity. This shared culture provided focus group members with a sense of having a communal understanding of the problems to be addressed, which allowed participants to discuss their challenges using the “we” pronoun, alluding to both their membership in the church but also their collective cultural experience. Although the perception was that stigma was especially strong in their racial or ethnic culture, their collective identity also seemed to provide a rallying point for engagement with mental health concerns.

### **Interface of study findings with scholarly literature**

The emergent themes represented the beliefs and perspectives of the focus group participants on how to demonstrate hospitality towards people with mental illness. This population of individuals with family members or personal experience with mental illness was seen as a critical stakeholder for mental health inclusion in the church. However, Corrigan (2019) has warned against well-meaning individuals who advocate for stigma reduction producing unexpected adverse effects, a phenomenon he has termed the “stigma effect.” Church leaders who promote hospitality towards people with mental illness could potentially fall into this camp if care is not taken to do so effectively. For this reason, the themes identified here are incomplete without being informed by the broader research literature. To strengthen the implications of this study, we synthesized the study findings with the existing research literature as we expected this would provide greater clarity of existing wisdom, as well as possible points of tension, that might minimize the stigma effect.

One theme that was elaborated in the study was the notion that hospitality practices were a form of special treatment for those with mental illness. Yet, this belief could have drawbacks that might engender hostile attitudes towards people with mental illness because it suggests that those with mental illness should receive privileged treatment within the church. The American Disability Act’s notion of reasonable accommodations might provide an alternative framework as it could frame hospitality as an expectation of all people, including those with mental illness (Corrigan, 2019; Yong, 2011). The hospitality practices for those with mental illness would be analogous to making churches wheelchair accessible or providing braille hymnals, which are simple efforts towards equitable treatment. Although these practices might require significant shifts in church models (Bishop, 2018), these changes would be reasonable in expanding a sense of belonging for the full continuum of mental health.

Another theme that emerged in focus groups was the fear of violent behavior by people with mental illness. This theme typically was addressed indirectly by participants, who referred to concerns about safety or the need for armed ushers while discussing hospitality towards people with mental illness. Yet, it is important to highlight that the notion that people with mental illness are dangerous is a stereotype that tends to engender fear and other prejudiced reactions. Although there may be a weak link between mental illness and violence (Corrigan, 2019), people with mental illness are far more likely to be a victim of violence than a perpetrator (Monahan & Arnold, 1996). This incorrect link between perceived risk and the actual level of risk suggests a need to educate church members on this

body of research, i.e., on the negative consequences of this stereotype of dangerousness as well as behavioral indicators and risk factors for violent behavior.

One general theme was the notion that hospitable practices were limited to the way that people with mental illness are treated rather than the roles and functions that people with mental illness could provide in the church. This theme was variable. Certain focus groups did mention service by people with mental illness or the idea of giving one's personal testimony, yet the discussion of these ideas was not consistently present. Thus, this seemed to be a potential liability for the church's efforts. This notion of unilateral hospitality could potentially foster a view that the church belongs to the mentally and emotionally healthy and that those with mental illness are merely visitors. Swinton (2015) challenged this notion by emphasizing that hospitality involves being both a guest and a host, as Jesus often exemplified in Scripture. Bishop (2018) argued that people with mental health challenges should be fully included in discipleship, leadership, and service within the church, even in the midst of their mental health struggles. Consequently, this points to the need for a more robust and constructive theological vision to include an understanding of how individuals with mental illness are incorporated into the life of the church and that the entire church can be served by and learn from those with mental illness.

Finally, certain themes that had been identified in past research were not clearly identified in this study. It was not evident that focus group participants saw people with mental illness as demonstrating heroism, as experiencing greater freedom through their limitations, or as "strangers in our midst," as Webb (2012) puts it. Similarly, participants did not state that mental illness offered opportunities for transformation (Scrutton, 2016) or that people with mental illness could be comforted by God's willingness to be one who suffered by dying on the cross (Scrutton, 2015). The absence of these ideas suggests that views of mental illness within the church could be furthered by providing theological concepts that might contradict prevailing stereotypes and prejudices.

## Implications for church leadership

The overarching goal of this project was to equip the Christian church in North America to provide hospitality towards people with mental illness. It was evident that, in many of the churches, there are already existing perspectives and resources that can provide a sense of belonging and care to this population and to all of those on the continuum of mental health. Yet, interpreting the study findings in light of the research literature also reveals the need for the church to be thoughtful about how to promote hospitality towards people with mental illness because of the inherent tensions.

When communicating with the congregation and the community, Christian churches have an existing language for faith and identity that should not be discarded. As noted by Lloyd and Waller (2020), the response to mental health issues ought to be culturally and spiritually sensitive. Yet, given the concern that mental illness is not always recognized as a valid disorder, churches should thoughtfully incorporate psychiatric and scientific concepts when addressing mental health to educate the congregation on the causes, conceptualizations, and treatments for mental illness. Training that provides education on symptoms of mental illness, as well as basic active listening skills, could be useful for empowering congregation members to provide this sense of hospitality. It might also be helpful to provide training related to setting appropriate boundaries due to the expressed concerns that people with mental illness might make significant demands on church members' time or energy.

Yet, training within churches should be careful not to perpetuate harmful stigmas about mental illness. Church members need to be educated about basic facts, such as the association between mental illness and violence being far weaker than the public generally believes (Corrigan, 2019), or else fearful reactions might inhibit a sense of hospitality within the church. Church violence prevention and safety plans ought to involve relevant training for ushers and church staff to be able to distinguish between warning signs of violent behavior and symptoms of mental illness, as well as reasonable education on the likelihood of violent behavior.

These trainings could be culturally tailored for the context of the church. The Asian American focus groups in this study seemed to consistently identify these training as necessary and would likely welcome them. In other contexts, the training might need to be framed differently to appeal to cultural values. For instance, training on mental health in Latinx churches could emphasize family concerns in both marketing and the actual content. Mental health hospitality training in African American churches could address concerns about homelessness, police violence, and family secrets in relation to mental illness. In multi-ethnic churches, leaders ought to consider the diverse cultural values of their congregation when developing a response.

Directly addressing these topics would likely validate people's experiences and aid in overcoming the cultural stigma of mental illness. Many churches have members who work in mental health treatment or who have knowledge through lived experience or family experience that could serve as resources for providing this education. Other resources could include small group curriculums developed to address mental health, such as Living Grace Groups (Rogers & Stanford, 2015). It should be noted that encouraging further education on scientific perspectives of mental illness contradicts Swinton (2015) discouragement of the use of psychiatric language within the church. However, some of the concerns he outlined still hold true, especially the avoidance of labeling people entirely by their mental disorder and promulgating an exclusively biological explanation of mental illness.

The perceived associations of mental illness with sin, weakness of faith, absence of faith practices, and demonic possession might not always be reflective of actual church teachings. Rather, these beliefs seem to reflect the "emotional prosperity gospel" (Mathison, 2016) that holds that faith can guarantee freedom from poor mental and emotional health. To counter this view, churches can provide sermons and teachings that acknowledge the complexity of the relationship between faith and mental health. The congregation can be informed of the inverse relationship between faith and mental illness (Bonelli & Koenig, 2013) but should simultaneously be taught that exceptions to this pattern exist for individuals as well as for particular disorders, such as schizophrenia and bipolar disorder. Such discussions ought to also acknowledge theological reasons that faith does not guarantee mental and emotional health. Theological resources from Scripture could aid in bolstering such constructive views.

When engaging these issues, there remains a possibility that churches could promote a dichotomy of "us" versus "them" in regard to mental health and illness. To avoid this, churches ought to convey that all people fall on a spectrum of mental health, with some people having mental health problems that are significant enough to be diagnosed. Emphasizing the continuum of mental health when communicating has been found to be associated with less stigma towards mental illness, including the belief that people with mental illness are "different," and encourages optimism about recovery (Corrigan et al., 2017).

Faith leaders should frankly and nonjudgmentally acknowledge that mental and emotional health problems can be chronic and severe in some cases. There should be an appreciation that humbly acknowledging one's weaknesses is a positive virtue. Although some

people can self-manage their recovery by seeking spiritual support, obtaining professional help can be another form of faithfulness to God. Together, this sort of communication could convey that people with these disorders belong in the church and will be empowered towards their own recovery.

However, it is important to note that hospitality means seeing people with mental illness as persons of equal worth. Sometimes Christians can be motivated to care for people with mental illness, similar to feeding the hungry, clothing the naked, caring for the sick, and visiting the imprisoned, by drawing upon the passage in Matthew 25 where Jesus says, “Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me” (Matthew 25:40 NIV). Yet, there is a risk the if we look at those with mental illness as the “least of these” in a social hierarchy this might reify the idea that people with mental illness are actually less than (Corrigan, 2019). Rather, faith leaders should be careful to remember that these sorts of hierarchies are cultural constructions and not based on the theology that all people are created in God’s image (see Genesis 1:27).

### Limitations and future directions

This study was limited to a small number of focus groups within Southern California and, as such, represents an exploratory data analysis in the form of qualitative data collection to aid in understanding the perspectives and viewpoints of hospitality and mental illness. Moreover, the churches had particular ethnic representations that may not reflect the tremendous cultural diversity within racial groups. Although sweeping inferences cannot be made with such data, our exploratory data analysis represents a first attempt to more fully understand mental health and hospitality while taking into consideration ethnic and cultural differences. As such, this research lays the groundwork for future qualitative and quantitative research by clarifying the motivations and barriers to hospitality of those within the church.

The findings are striking in pointing out resources within the church that the research literature has overlooked. Studies have focused on specific aspects of church perspectives and practices, with numerous studies on how mental illness is viewed as demonic possession, deficient faith practices, the result of sin, or an invalid diagnosis (Hartog & Gow, 2005; Stanford, 2007; Stanford & McAlister, 2008; Wesselmann et al., 2015; Wesselmann & Graziano, 2010). Other research has focused on antagonistic views of therapy and medication (e.g., Polson & Rogers, 2007). This study provided qualitative data for the concept of hospitality that was highlighted by Swinton (2015) as relevant to the church’s response to mental illness. This concept should be explored in more depth to better understand how it relates to positive experiences of those in the church who are living with mental illness.

Moreover, this study investigated cultural differences in the understanding and practice of hospitality within the church. Although some research has looked at specific racial or ethnic groups in regard to treatment of people with mental illness within the church (Allen et al., 2010; Caplan, 2019; Okunrounmu et al., 2016), this study was perhaps the first to look at cross-cultural differences in church perspectives and practices towards people with mental illness. Further cross-cultural research would be useful in generalizing the findings beyond the churches studied here, looking at additional particularities and commonalities in these responses. Research could also investigate how the presence of particular cultural values, such as collectivism versus individualism or an honor culture, could impact the church’s response to mental illness.

Future research could potentially investigate the impact of systems-wide interventions to teach relevant perspectives and implement practices that would further hospitality towards people with mental illness in the church. For instance, there is a lack of research on the effects of speaking about mental illness from the pulpit. Moreover, a curriculum that addresses some of the theological and cultural barriers could be created and implemented. Quasi-experimental studies utilizing pre/post design could investigate the utility of such interventions for fostering a sense of belonging, alleviating the burdens of stigma, and perhaps even improving symptoms of mental illness. Continuing to engage in robust research on this topic would lead to fruitful insights that could equip a more compassionate and hospitable response to mental health problems in the church.

**Funding** The preparation of this article was supported by a generous grant from the Louisville Institute. We are indebted to all our colleagues and authors collaborating with us on the Louisville Collaborative Inquiry Team. Supplemental funding was provided by the Provost's Office at Azusa Pacific University through a Faculty Research Council grant.

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