ASHLAND THEOLOGICAL SEMINARY

DISCOVER KNOWLEDGE, ATTITUDES, ACTIONS ABOUT MINISTERING TO THE MENTALLY ILL IN THE CLEVELAND DISTRICT

A DISSERTATION SUBMITTED TO
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BY

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DEDICATION

To my brother, Robert and all of my siblings

EPIGRAPH

A Mental Health Condition Is “In God’s Hands”

African-Americans need to know: A mental health condition is no different than a physical one. Our brains are the most important organ in our bodies and can get sick just like our hearts, lungs and livers. Not only that, you *can* recover from a mental health condition and lead a healthy life. Further, African-Americans are not immune from mental health conditions.

-Fonda Bryant, National Alliance on Mental Illness
March 30, 2018

APPROVAL PAGE

Accepted by the faculty and the final demonstration examining committee of Ashland Theological Seminary, Ashland, Ohio, in partial fulfillment of the requirements for the Doctor of Ministry degree.

Academic Advisor	Date
Director of Doctor of Ministry Program	Date

ABSTRACT

The project purpose was to discover the knowledge, attitudes and actions of parishioners about ministering to the mentally ill in the Cleveland District of the AME church. A survey questionnaire, with 3 sections of 16 questions each plus an evaluation section; was distributed to AME members and clergy in the District; with 33 Black AME church members responding.

The results of the project revealed that respondents know mental wellness is a vital part of overall health, mental health services are available; plus church members are willing to engage in ministries that provide mental health resources and work in support ministries.

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ACKNOWLEDGEMENTS

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To my brother, Robert, who struggles with mental health.

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To the churches I Pastored, St. John AME in Struthers, OH; Greater Mitchell Chapel AME in Mansfield, OH and Jones Chapel AME in Elyria, OH

To my staff who allowed me to be me.

To my Lord and Savior who loves me unconditionally. Without him, I would not be here.

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CHAPTER ONE

INTRODUCTION AND PROJECT OVERVIEW

Not only is life hard; living life is unpredictable and it is doubtful we are prepared for what living teaches us. One of the awesome things about the work and ministry of Jesus is how he taught the masses life lessons through the use of parables. With the utilization of real-life situations in his ministry, Jesus taught and demonstrated what he wanted to see in all believers. Parables during Jesus' ministry have some similarity to reality TV of today. In reality TV, one may get to vicariously experience life as it unfolds and become one of the characters in the "real life drama" due to familiar or similar circumstances. The difference is found in the life lessons that are learned; that is, those that bring us closer to Jesus and those that make us pull away from His teachings. This project, on mental health, is reality TV for me and my family.

My mother had eight children: four girls and four boys. In being the sixth child, whenever any problem would send me to our mother to complain about another sibling, she would always say, "Now there is something wrong with all of my children. But you seem to have it all together." When the conversation ended, you felt that everything was all right with you, but the one you were complaining about was a little crazy; thereby requiring you to be more tolerant, patient and forgiving. During all of the many discussions with my mother concerning the mental stability of my other siblings' one would have strongly believed that all of her children would and could understand each other's weaknesses. Because of the love we had for each other, we were able to adjust our interactions by

becoming more tolerant and patient with each other. Because my mother had the same conversation with each of her children, I do not know whether it was a coping mechanism for my mother or whether we all have serious mental flaws that were trying to make their way out into the open. When my brother was diagnosed with a mental illness it was shocking but the mental flaw had made its way out into the open and this time it would take more than a conversation with my mother to make everything alright. On that day, the statement, “we are all a little crazy,” took on a whole new meaning.

Purpose Statement and Research Question

The purpose of my project is to discover the knowledge, attitudes and actions of parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME). My research question is, “What are parishioners’ knowledge, attitudes and actions regarding ministry to the mentally ill?”

The project focus is to discover the resulting attitudes and actions of members when they were informed about mental illness within the church family. This project will hope to reveal attitudes about mental illness, as well as actions around mental health support ministries. The function of the project will discover the knowledge concerning mental illness, the attitudes surrounding the disorder and determine the actions taken by AME parishioners and the AME church

community for a current or former, faithful church member dealing with a mental health challenge.

Overview

The ultimate goal of this work is to acknowledge mental illness as a disorder; to identify what we know and what we do not know, acknowledge the various attitudes concerning the disease whether grounded in fear, shame and lack of education; and to develop ministries within the AME church that would aid persons diagnosed with a mental illness. In addition, this project will shine light on aiding and transforming the church community in acceptance of all people. As a part of this project, not only will surveys be developed to capture information; but workshops will be held that will engage attendees and encourage conversations with those impacted by mental health conditions.

Foundations

The foundation of the project is grounded in God's word, God's teachings and God's promises. The scripture lesson, Mark 5:1-20 (NIV), which focuses on the demon possessed man isolated in a prison condoned by his family and community. This revealed what it must be like to be locked in a prison within your church due to conditions beyond your control. The similarity between the scripture and the real life drama of my brother drove my efforts to fully understand the total connection of God's presence and actions in the life of a

person dealing with a mental health issue. In life, not all stories or dramas end the way that we pray or hope. Sometimes the timing of the life lesson can still be in development and has not been learned by the community or the person. Sometimes we do not understand why God shows up in ways that do not appear supportive. However, like it says in Hebrew 13:11, Jesus is the same today, yesterday and forever more (NIV).” Meaning the life and work of Jesus is the same and therefore if Jesus showed up in your beginning, Jesus will show up in your life for your yesterday, today and your forever.

Personal Foundation

The family dynamics were so different, beliefs concerning mental wellness were different; so, what could be done to help my brother, if we could not come together as a family? We gathered for prayer at his house, we called in all the prayer warriors, we anointed the house, furniture and all belongings with oil, we read the bible and then we prayed away all spells, curses, sin and demons. At the hospitals, we laid hands on him and prayed. A lot of the family began to walk away; the task was too large and the time commitment too great. Engaging family with different views on the illness with dissimilar ways to tackle the issue was a monumental undertaking. I constantly heard, “money was no issue, so you get him the best doctors. Why can’t you get him to listen? Did you call his job? Did you talk to his doctors? When are you going to see him? What is going to happen next?” It was a challenging and discouraging time when just having a conversation with my brother or family became a hurtful experience. The strength

to get through the trials where different beliefs showed up with various levels of faith and hope in God, did not net the desired results and it was overwhelming. Searching for help left us all wondering where was God. The family was in a state of confusion. My personal foundation was in God and Jesus, who promised to never leave us nor forsake us (Deuteronomy 31:6, Deuteronomy 31:8, Joshua 1:5 and Hebrews 13:5 NIV).

My personal notes will document where this mental health journey has taken me. My research will focus on the events and steps that outlined the course where my brother started his journey and his progress in adapting to his "new normal." Because I do not know the story, I cannot recreate the past. My knowledge of him is based on growing up with him, before college and now. There are no past medical records due to HIPAA laws. In wanting to believe that there is a way out of a mental illness that leads to a 'new normal' that is not focused on isolation and fear, the overriding goal is providing one-on-one assistance to bring him back to the 'old normal'. In searching for reading material, most of the effort was looking for success stories of overcoming mental illness that identified the challenges and how the person navigated through it. In talking to people in and out of church about mental health, the next steps were exhausting because information and lack of credible information had me going in circles. I concluded that the problem was much bigger than the two of us; that in order to see real change there would be a need to engage this issue as his family, his church family and his community.

Biblical Foundation

The biblical foundation for my project is found in Mark 5:1-20 (NIV). In the NIV bible, this pericope of scripture is titled, “Jesus Restores a Demon-Possessed Man.” Looking at the traditional perspective according to the *New Interpreter’s Bible Commentary* for the Gospel of Mark, this passage of scripture is about the exorcism of the Gerasene Demoniac, which is one of the first miracles attributed to Jesus. From the biblical viewpoint, the scripture lesson is about a man who was different. But because of Jesus’ selfless actions, this man became a wonderful witness of the miracles and saving power of Jesus.

In a non-traditional perspective, that was written by Hisako Hinukawa, “Some scholars point out possible social or cultural allusions: the possessed or mentally disturbed man might symbolize disabled people unable to maintain proper social relations in their community. The man’s abnormal behavior might be his way of struggling with harsh circumstances” (Kinukawa 2004, 369). Living in places of poverty is not on the list of being socially unacceptable, but being a Jew could result in being culturally isolated and being deemed ‘mentally disabled’ left the man isolated from society. Hinukawa stated, “Though living, he is treated as dead. Physically isolated from his kin, totally marginalized from the community and considered unclean, he is socially alienated as ‘other.’ In sum, he symbolizes society’s outcasts” (Kinukawa 2004, 369).

The mentally ill are society’s outsiders, throwaways or recluses. We avoid, we segregate, we isolate, we form opinions and we dictate how those who are somehow different from us should exist by imposing the values of society.

In the exegesis of this passage of scripture, multiple traditional and nontraditional commentaries will be used. The demon possessed man is imprisoned by the community and family. Exegesis of the passage will allow a deeper dive into the cultural and social ramifications. For the black community, the church is where we have always found a place, where all are accepted. The black church is where one goes to affirm their "purpose" and "identity." You can count on those within the church to lift you up and not cast you aside because you are different. Biblical evaluation will guide us to full restoration, back to normal by Jesus.

Theological Foundation

In connecting the theology of God with the Christology of Jesus, I will discuss provision, protection, change and promise. Even in knowing that God is the Supreme Being, God's presence did not always bring peace, joy and acceptance for the demoniac; nor today for those who suffer with mental illness. Due to imprisonment and isolation, there were some unexpected consequences that at times appeared to be inhumane and not in the likeness of Jesus. The book, *God of the Oppressed* by James Cone, speaks to the struggle of the black race. "If Jesus Christ, in his past, present and future, reveals that the God of scripture and tradition is the God whose will is disclosed in the liberation of oppressed people from bondage, what then is the meaning of liberation" (Cone 1997, 127)?

From the depiction of the demoniac in the scripture, to our African ancestry point of view, to slavery and from being black in America, to the

unintentional side effects of mental illness, from just living life, I will unpack multiple theologians and their thoughts. The project will seek to identify God and focus on his action in enabling the church to become a place of healing, acceptance and value for those with mental health challenges.

Historical Foundation

It is very difficult to separate theology from the historical role of the church for the black race. The historical role of the black church as the primary caregiver and the barometer for the black race not only was in the forefront of this project's research, but it is the church that molds who we are as a race. My project is concerned with the members of the African Methodist Episcopal Church and their interaction with those who have mental health challenges. Mental health concerns that may have existed since birth or have been displayed over time are now placed on hold by the church because the church is either struggling with what to do next or it is just easier to ignore. According to Anthony B. Pinn in *The Black Church in the Post-Civil Rights Era,* "The Black Church has presented itself as the strongest institution for social reform within Black communities. Church members used the history and insights of the Black church to act and remain strong and provided ministry throughout the world" (Pinn 2002, 17). Yet, historically, it appears that the church did not continue to realign herself as the needs of the community changed. The project will attempt to discern what happened that caused the momentum to diminish and the church to not see the needs of those who were struggling with mental health issues? The church

appears irrelevant to those who are suffering; like the poor, the homeless and the mentally ill.

In the black community, we seek out the church for unconditional love and encouragement and through that community engagement, there we gain a sense of strength and empowerment. For a lot of people, the church has been the community where ‘living life’ takes place. The sense of community found in the local church was nurtured from childhood and for most members, the church becomes the safe place to thrive or fail. My project will seek to examine the historical views and actions of how the church has evolved in dealing with members who are diagnosed with mental health challenges.

The contemporary view challenges the church and community to find ways to overcome the stigma of the disease by changing the narrative, which can come in multiple forms from many sources. Today, we look at how and why things are changing. Contemporary sources on mental health included novels, where individuals have told their stories; books where research has revealed the mounting problems that come with seeking and making recommendations for solutions to real life issues found in lived experiences with mental illness; and open conversations concerning the ins and outs or ups and down of the disease. The discovery process will open the door to past behaviors and pave the way to the present; as research has revealed the same inquiries; that is, where is the church on knowledge, attitudes and actions for church members and their families that are participants, even though they may be unwilling participants, of mental health trauma? The question has been asked in multiple ways and the

answer is still fleeting in the AME church. How or how well do we help members with mental health needs through ministries of support and resources? The challenge will be to define a new, fresh approach to work with and create ministries that impact change in the life of the mentally ill and their families.

In the book, *Blessed are the Crazy,* Sarah Griffith Lund states, “The complexity and chronic nature of mental illness means that the disease does not go away easily or quickly. These characteristics of mental illness make it difficult for faith communities to know how to respond in ways that are both meaningful and healing” (Lund 2014, 95). Today, we find those that are suffering with mental health concerns asking questions that need answers and the church has not stepped up yet because the church is still trying to determine the correct course of action. Lund also says, “Churches can create environments in which it is safe to tell the truth about mental illness by inviting people into small groups to share their own personal testimonies of struggle with the disease” (Lund 2014, 97).

How long will it take the church to rise to the occasion or make a change that impacts and includes all people? Maybe, the church needs to pray and seek guidance, pray to expand resources, pray and open their hearts, and pray that God will direct the church to take a different approach. Are we there yet? What would it take for the church to listen to a person diagnosed with a mental health condition? Today’s generation is not just willing to accept the church doing the same things that was done fifty to one-hundred years ago; they are seeking real efforts toward change and real ministry as the result. Multi contemporary resources will be used.

Context

The context of my project is the AME church and its members in northeastern Ohio. The project will seek to identify the church's attitude on ministering to the mentally ill and how this church supports members that are mentally challenged. Again, this project is about ministry and how we minister to those who are considered mentally different. The focus of this project is to discover the knowledge, attitudes and actions of parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME). The project happens in, around and is connected to the AME church that was founded in 1787. Ministry and change happens in community and it is in community where we find those with the most challenging needs.

Sometimes change represents forward movement and this project will evaluate change or lack thereof with the church and the members. The stronghold of mental illness is so powerful that the escape from the stigma becomes overwhelming and crippling. That statement was true when I started my project so the question remains as to why more action has not been taken to change this mindset within the church. When a mental health diagnosis holds the person captive, the mentally challenged are lost within their mind and cannot free themselves without help. When the church is held captive by fear due to old beliefs and lack of knowledge, then the church also needs help.

Project Goals

The focus of this project is to discover the knowledge, attitudes and actions of parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME). The project goals are as follows:

1. To evaluate the secondary literature on the subject matter.
2. To discover the knowledge of parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME).
3. To discover the attitudes of the parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME).
4. To discover the actions of the parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME).
5. To evaluate the study.

Design, Procedure and Assessment

The survey tool was designed to capture as much information as possible without becoming overwhelming. It was designed to start

conversations, disturb the comfortable, and create opportunities to discuss ministry. Because there were so many questions that needed answers, my project will be a discovery project, among members of the AME church. Mental well-being is just as important as the person's spiritual belief that one day they will live with Jesus in heaven. Does the mental state of an individual prevent that person from having a relationship with Jesus? Procedures will focus on getting members of the AME church, in the Cleveland District, to complete the survey, and start conversations.

A person who is suffering with a mental health issue needs assistance in dealing with being accepted in the life of the community in which they presently exist. Mental health concerns that have changed a person may be with that person for a prolong period of time, depending on what the condition is and could now represent the "new normal." The church community has a difficult time with making this adjustment of acceptance. Assessment will allow the opportunity to address incorrect information, change the attitudes that are founded in fear and create opportunities to start impactful ministries.

Personal Goals

Not knowing the facts on mental illness placed me at a disadvantage in seeing signs that shows someone has a mental imbalance. Because I have been talking about my brother's illness for almost five years, I used that as a platform to see if other people had similar stories, possessed knowledge concerning the

disease, developed good or bad attitudes toward a person with a mental health concern and were they willing to do ministry. My personal goals are as follows:

1. To obtain a better understanding of the various ways God intervenes in the life of those who suffer with mental illness.
2. To obtain a better understanding of the various ways God uses spiritual restoration for people that are sick.
3. To continue to educate myself and the church on how God's instructions defines our actions in adjusting to change.
4. To work harder to preserve my own health so I can be a better pastor.

There are many people who do not want to acknowledge that mental illness exists within their family. I think it is rare to find a family where there is not someone within the family with an obsessive behavior disorder, dementia/Alzheimer, hoarding or depression. What is concerning is that church members are quick to let me know mental illness does not exist in their family.

Plan of the Paper

This chapter has given an overview of the challenges and immanent difficulties to having meaningful conversations in order to address the knowledge, attitudes and actions for mental illness. There is not a roadmap that one can follow that will guide you into engaging a person. Chapter Two will describe the biblical, theological, and historical foundations for this project. The chapter will allow a person to see God and Jesus at work in the life of a person who was seen as a violent outcast. It will review God's protective power when the demoniac is separated from community and then restored. Chapter Three will

describe the review of the literature written by others on how they have coped with mental illness surrounding family members and themselves. From the person being diagnosed to those that were caregivers, mental illness can impact the life of all who are around us. Chapter Four will describe the design, method and procedures utilized in the project. It will describe the startup for the project along with developing the assessment tool, research and why the project was important. Chapter Five will report the results of the study. Surveys that were returned, along with the resulting analysis, will be outlined and the most prominent findings will be presented. Chapter Six will present reflections gleaned from the study; what have I learned; what will I change; and what I will I next. The chapter will also speak to where we appear to be going as shown by the survey findings.

CHAPTER TWO

BIBLICAL, THEOLOGICAL, AND HISTORICAL FOUNDATIONS:

This chapter will describe the biblical, theological and historical foundation of my project. The community of the black church is grounded in the word of God. The bible is the moral compass in the black church and guides ones very life. As stated by Cain Hope Felder in *Troubling Biblical Waters: Race, Class and Family,* "African Americans have sought ways, at times ingenious, to affirm themselves and their biblical faith. The Black church reflects a history of creative adaptation and usage of the Bible that is distinctive, but not always favorable regarded by others" (Felder 1989, 51). But to the black community, we look to the bible for direction and support no matter what the storm or trial of life. Knowing that the church is the stable structure of the black neighborhood that values and loves unconditionally, all too often the mentally challenged person does not receive with open arms the benefit of total acceptance from those who believe in God.

The theological foundation walks us through God and God's involvement in the life of his children. The how, why, when and way that God shows up in the life of the African American believer will certainly have an impact on a person's definition of who God is. From the theological perspective of a 'providing and protective God', where is this God for the hurting, especially those that are dealing with mental health concerns that evolve into a mental health crisis because of the action and/or inaction of others; especially from church members?

The historical journey, from Africa, to slavery, to Jim Crow, to the Civil Rights Movement, to our present time, the black church and black community have been victorious. In the past, the black church and black community aided in creating greatness and changed lives. George Singleton wrote in *The Romance of African Methodism: A Study of the African Methodist Episcopal Church*, "The rise of African Methodism in the United States during the latter part of the eighteen century was no mere accident. It grew out of the spirit of the times and represents in a concrete way the doctrine of the Rights of Man – a social and political philosophy then current in England and Europe, and whose influence was felt in America" (Singleton 1952, 1). Today, the African Methodist Episcopal Church (AME) church, not only appears to be silent on mental health matters, but has not created pathways to educate church members on how to love and value all people; including the mentally challenged.

> Historically, the African Methodist Episcopal Church was created to provide educational opportunities, leadership development and to address the challenges of committing to provide for the needs of all people. George Singleton's book, "Romance of Methodism," captured how the A.M.E. church elevated the "Negro" from just being a slave to the White man to becoming the impetus for greatness in the Black race. Singleton's purpose in writing this book was to capture the spark, the fire, and the essence of the Methodist movement among the African American race. The church emerged as a sustainer of human dignity during a time when the African American person was considered less that a full person and, in a time, when an African American person was considered property that could be sold to the highest bidder with no regards for the person, family or community. (Tyson 2007, Lecture)

Together, the biblical, grounded in the word of God; the theological built on the presence of God and the historical foundations of the church that are constructed on God's promise; all show the struggle of oppression

for the black race. Singleton says, “The influence and power of slavery was felt keenly by the early Fathers of the AME church, but in their zeal for the kingdom they blazed paths where highways never ran. They are unknown to the present generation but their sacrifices of tears, beatings, imprisonments, insults, and untold hardships were not in vain. God buries His unknown, but His work goes on” (Singleton 1952, 116). Today, we still must continue to grow stronger in the midst of change and oppression within the very church that was birthed to support the needs of all.

Biblical Foundation

The biblical foundation for my project is grounded in Mark 5:1-20 (NIV-New International Version). In the NIV bible, this pericope of scripture is entitled, “Jesus Restores a Demon-Possessed Man.” The title alone implies restoration from what was not normal back to what is considered acceptable. A traditional perspective, according to Pheme Perkins in the New Interpreter’s Bible Commentary for the Gospel of Mark, this passage of scripture is about the exorcism of the Gerasene Demoniac, which is one of the first miracles attributed to Jesus. This passage of scripture implies it took a miracle to see the man as normal again. If it was going to take a miracle to rid the man of the things that labeled him demon possessed; then what does it take for Jesus to help us adjust to a time when mental health challenges are increasing.

Today in the 21st century, the label, demon possessed, is still being used because mental illness is sometimes viewed as an evil spirit. Today, mental

disorders can be treated. Due to medical advances, there are trained physicians and new medications that are able to restore individuals back to wholeness or make them better than they were by improving their mental health. From the biblical viewpoint, the scripture lesson is about a man who was different. The question is asked, “what held this man in this prison?”

The biblical perspective of Mark 5:1-20 allows us to see the challenges of acceptance, hopelessness and fear, which are inclusive of the distance the person and the community had to travel to get to restoration of the person. When Jesus shows up in the life journey of the believer, the power of Jesus shines through as the light that leads a person out of darkness into wholeness. Perkins reference offers a traditional perspective and makes the following points concerning the beginning of Jesus’ ministry as he teaches, heals and transforms lives: “Jesus is breaking down barriers that separate Jews from Gentiles and separating the clean from the unclean” (Perkins 1994, 582).

“They went across the lake to the region of the Gerasene. When Jesus got out of the boat, a man with an impure spirit came from the tombs to meet him” (Mark 5:1-2 NIV), God and the demons meet face to face. Jesus is now making himself known to others and is impacting the life of the ‘least of these,’ those that are not accepted. “The sea, which might have been a barrier between the two ways of life, will hereafter be crossed repeatedly” (Perkins 1994, 582). Jesus’ mission was for all people to be made whole. The ministry of Jesus included the miracles he performed in the life of the believers. Jesus’ actions in community with others served as God’s calling card for the gathering of all people, including

the Gentiles; so that religious stereotypes were broken or destroyed. Yet, today, the church does more to support stereotypes than aid in breaking them down. The church no longer takes a lead role in changing the community.

In the prison, “there is an unclean spirit present. Impurities are piled one upon another. In the scripture, a man is living among the tombs, living among the dead and living among a large herd of swine” (Perkins 1994, 583). “This man lived in the tombs, and no one could bind him anymore, not even with a chain” (Mark 5:3 NIV). One wonders, what held this man in this prison? His ability to free himself demonstrated to all that he could leave at any time and it was not the chains that held him in place. Was the man just as afraid of leaving his surroundings as those around him were fearful if he lived among them? “For the man had often been chained hand and foot, but he tore the chains apart and broke the irons on his feet. No one was strong enough to subdue him” (Mark 5:4 NIV). His mind conditioned him to stay in his place.

“Night and day among the tombs and in the hills he would cry out and cut himself with stones” (Mark 5:5 NIV). Perkins tells us, “the description of the possessed man raving among the tombs would evoke the horror of being outside the ordering power of civilization” (Perkins 1994, 583). The struggles of life and the impurities of life that surround us are not singularly focused or isolated; and the effects are crippling. Challenges of living and trials coming from multiple sources, all converging at one time or at multiple times and in multiple ways, will affect ones’ mental balance. There are many reasons, several concerns and numerous things that each of us must deal with in just living life. Juggling all of

the things that life hands us, without a solid support system will result in a person withdrawing from the problem and society. According to Perkins,

> Social tensions can be enacted and resolved through exorcism rites. Pre-modern culture suggests that here is no reason to reject the tradition that Jesus was an exorcist. Demons were believed to harass persons from outside, in other words, to take over an individual's personality. Exorcism of a demon within the man has been requested by the community, yet this is not the normal exorcism story. (Perkins 1994, 585)

"When he saw Jesus from a distance, he ran and fell on his knees in front of him. He shouted at the top of his voice, 'What do you want with me, Jesus, Son of the Most High God? In God's name don't torture me" (Mark 5:6-7 NIV). Perkins says, "Although his rushing up to prostrate himself before Jesus suggests a gesture of worship appropriate to Jesus' identity, the demoniac's words reflect a desire to drive Jesus away that is characteristic of the exorcism genre" (Perkins 1994, 583). When the man saw Jesus, he saw the power of Jesus and surrendered. When the demon saw Jesus, he saw the power of Jesus and knew Jesus' power was greater than his power. The demon realized the end was near. Furthermore, Perkins claims, "The demons have stripped the man of every shred of humanity. The community has stripped the man of his hope. This situation has created signs of social and religious chaos" (Perkins 1994, 582-583).

"For Jesus had said to him, "Come out of this man, you impure spirit" (Mark 5:8 NIV)! "The demon recognizes Jesus as the Holy One of God from a distance" (Perkins 1994, 583). The exorcism reveals a demon who not only knows that there is a superior power that is present; but the demon also has prior knowledge and knows the name of this Supreme Being. The blurred realities are

now becoming clearer and the man is able to see the impurities as a cause of concern because he recognizes Jesus. Not only does the demon recognize God, but the man recognizes Jesus as the Holy One of God.

"Then Jesus asked him, "What is your name?" "My name is Legion," he replied, "for we are many" (Mark 5:9 NIV). When we give a name to what is our struggle and to what is our pain, we are on the road to recovery. We acknowledge that there is a problem. The demon responds with a name, but not just a name of one thing; but of many. Our life struggles are many and we have to deal with them in different ways. Perkins argues, "The demon's name, Legion, implies a large number of people and contains a veiled reference to the devastation of people and property caused by the Roman occupation. God's kingly power has subdued imperial domination" (Perkins 1994, 584). The man's life changed due to retaking the power he had given to demons and the impurities in his life.

> And he begged Jesus again and again not to send them out of the area. A large herd of pigs was feeding on the nearby hillside. The demons begged Jesus, "Send us among the pigs; allow us to go into them." "He gave them permission, and the impure spirits came out and went into the pigs. The herd, about two thousand in number, rushed down the steep bank into the lake and were drowned. (Mark 5:10-13 NIV)

Based on Perkins, "There is a violent sign of the demons' exit from the man; the demons escape into the swine; then into the sea; and then drown themselves" (Perkins 1994, 584). The problem: Sins and fears that we carry with us come in multiple versions, with various levels of power and can overpower us in multiple ways.

From the scripture, we know the approximate number of swine, but not the number of impure spirits. What becomes overwhelming is when the number of 'impure spirits' overpower the host.

> Those tending the pigs ran off and reported this in the town and countryside, and the people went out to see what had happened. When they came to Jesus, they saw the man who had been possessed by the legion of demons, sitting there, dressed and in his right mind; and they were afraid. Those tending the pigs ran off and reported this in the town and countryside, and the people went out to see what had happened. (Mark 5:14-16 NIV)

Jesus is now changing the belief structure within the community. Based on Perkins, "The individual has been healed and people see the man, who was once completely asocial, is now in his right mind and wearing clothes" (Perkins 1994, 584). Jesus restores the man back to the plan that God has for his life; but the man is still imprisoned.

Jesus is now using witnesses to spread the news. The man looks normal, he acts normal; but he is not welcomed back into the community because society still sees him as the deranged man who lived in the tombs. The action of God healed the man, but the healing action along did not rid the community of its fear. "Then the people began to plead with Jesus to leave their region. As Jesus was getting into the boat, the man who had been demon-possessed begged to go with him. Jesus did not let him come, but said, "Go home to your own people and tell them how much the Lord has done for you, and how he has had mercy on you" (Mark 5:17-19 NIV)." The people do not know what to think of a man who can cast out demons. They are concerned that this man could probably harm them and could place them in danger.

Furthermore, Perkins contends “Jesus sends the man home to family and friends. Jesus empowers him to preach the good news and to go out and tell others about his change. The Gerasene man becomes Jesus’ first Gentile missionary” (Perkins 1994, 584-585). The man becomes a change agent for God when Jesus sends him back home. The only problem is that the community does not see a changed man. The community still sees the demon possessed man and all his impurities that caused their initial fear.

“So the man went away and began to tell others in the Decapolis how much Jesus had done for him. And all the people were amazed” (Mark 5:20 NIV). The man becomes a witness for Jesus’ saving power. The number of witnesses increased daily; first, those tending the swine, those who came to witness the death of the swine, the release of the changed man and now those interacting with the changed man. This new man is now a witness to the saving power of Jesus and is no longer comfortable in the tombs; even though he was still feared by some in the community. The change for the community is evolving to be more inclusive of Jesus’ power and to open their minds to the possibility of all the things Jesus has already done through grace and mercy for all people.

The exorcism represents how we can control good and bad within our world. Perkins argues, “This exorcism story is a dramatic illustration of Jesus’ earlier claim that his exorcisms represent the binding of Satan” (Perkins 1994, 585). Satan lives within us. Satan is found in the fear of those living in the community. This exorcism may bind Satan for the man, but the exorcism does not bind Satan for the larger community. We look to the bible for direction and

support no matter what the storm or trial of life; yet the mentally challenged person does not receive with open arms the benefit of total acceptance from those who believe in God. The church is no longer the base for solidarity for support. Perkins lets us know, “In many of the miracles and exorcisms of Jesus, healing involves breaking down traditional boundaries so that person’s formally excluded from the community are included” (Perkins 1994, 585).

Another traditional biblical view is offered by William L. Lane in *The New International Commentary, The Gospel According to Mark.* The focus is a violent man who lives in the tombs. The author titled this passage as the Gerasene Demoniac: The Subduing of the Demonic. According to Lane, “Jesus could not avoid a significant confrontation with demoniac possession. The function of demonic possession is to distort and destroy the image of God in man” (Lane 1974, 180). To be lost in your mind destroys your ability to focus and hold onto the God in you. What is not of God is never a benefit. The ultimate goal is to see Jesus in the man and not see a distorted vision of their own beliefs. We, who are part of the community should be able to accept the differences in other people without labeling the person as an outcast. Lane tells us, “In accordance with the practice of the day they had attempted to bind him by chains to protect themselves from his violence” (Lane 1974, 182). For all people, acceptance is the key, so the attempt to bind the man went beyond the chains that held him in place, to controlling him through isolation within his community; to ultimately controlling his mind.

The people created a ‘new community’ for those who were different and were once welcomed as part of the community. Lane informs us,

> The people of the town thought the man was mad, for his appearance and behavior conformed to the popular diagnosis of insanity. The attitude and actions of the people of the town were an added cruelty based on their popular misunderstanding. They had driven him off to wander restlessly in the wild hill country and to dwell in the subterranean caves which served as tombs and dwellings for the poorest people of the district. (Lane 1974, 182)

People were afraid of the man; therefore, he was left alone in prison with his own thoughts and faults. The man grew weak in spirit, in mind, and will power. As the man became more invisible to those around him, the easier it became to see him as a confined prisoner that was safe from harming others; thereby creating the illusion of a safer community.

Fear was a mighty force at that time and is still so today. Lane tells us, “The ultimate responsibility for the wretchedness of the man and the brutal treatment he had endured rested with the demons who had taken possession of the center of his personality” (Lane 1974, 182). Precepts and assumptions are always in place before the facts are known creating hysteria, fear and doubt. Even today, we do not take the time to learn before we act. Because of the unknown, the man was placed in a man-made prison, bound and chained within his mind and bound and chained within the community. Stripped of life, the man learns to exist and not live by wondering through the tombs of life.

When we do not see an end in sight and we do not see help coming, we look to end stressful situations through methods that may be harmful to all. To paraphrase Lane as he describes the present situation:

> The demon is fully aware of Jesus' divine origin and addresses him as Son of the Most High God. The demon's address to Jesus was to gain authority over him by calling him by name. The demon senses he is to be punished, invokes God's protection but fails because Jesus is the Son of God. Jesus is sufficiently powerful that the demon at once understands that it must leave the man. The man's action of shrieking and cutting himself with stones was evidence of the man wanting to bring to an end to the torment of an unbearable existence. (Lane 1974, 182-184)

Demons were seeking to gain a superior position in this encounter with Jesus, the man, and those in community. The demons feared for their demise and needed to gain an upper hand by instilling fear in all. The unknown is always a problem for those of us who live in community; even for the demons. Lane claims, "Jesús now demands to know the name of the demon and for the first time there is indicated the full degree of distortion to which the man was subjected; not one but a multitude of alien forces had taken possession of the volitional and active ego of the man" (Lane 1974, 184). As revealed by both Perkins and Lane, the demoniac knew Jesus by name. We know the demons in our life. We all have free will, but our decision making is impaired when one's self-worth is diminished. The man's name is not revealed in the scripture, but he is described as demonic and the demons' name is Legion. Lane claims, "It is probable that the many demons can be referred to as a single being because they are in common possession of the same victim, but it is not possible to ascertain the exact nuance expressed in the term Legion" (Lane 1974, 185).

Moreover, according to Lane, "The fate of the swine demonstrates the ultimate intention of the demons with respect to the man they possessed. It is their purpose to destroy the creation of God. Being halted in their destruction of the man, the demons fulfilled their purpose with the drowning of the swine" (Lane

1974, 186). The demons came to destroy by any means necessary. The demons leave, but not without making adjustments. Now God is about to fulfill his purpose through destruction by granting the request of the demons. Lane says, “The purpose of the swine was to destroy the creation of God, and halted in their destruction of a man, they fulfilled their purpose with the swine” (Lane 1974, 186). Then God fulfilled His ultimate purpose of healing and restoration.

Additionally, Lane argues, “So radical was the transformation of the man that the townspeople were stunned and frightened” (Lane 1974, 187). The man who had been possessed was seated, clothed and restored to wholeness of mind. The people, fearful of the unknown, was now afraid of Jesus and asked Jesus to leave them. Lane says, “As Jesus prepared to leave, the man begged Jesus to allow him to go with him” (Lane 1974, 187). Jesus demonstrates his power over the demon and change happens. Removal of the demon, the fear, the safety net by Jesus propels the community into fear of Jesus. Lane reiterates that, “Jesus refused the man permission to accompany him, but instructed him to return to the circle of family and friends from whom he had been estranged and to declare all that the Lord had done in extending mercy to him” (Lane 1974, 188). The healed man became a witness to the power of the Father through the work of the Son. The man who was once violent and could not contribute to society has been reengaged and restored. In the midst of the Gentiles, “the God of Israel was glorified through the proclamation of what Jesus had accomplished” (Lane 1974, 189).

The community has served as witnesses to an individual who was once a free member of society to now being witness to a person deteriorating before their eyes because of a change that could only be explained as demon possessed. Jesus, in the past, was preforming miracles and this exorcism resulted in a miraculous restoration. The man now wants to tell others about the saving power of Jesus. To recap and look at the similarities between Perkins and Lane is as follows: 1. Jesus is in Gentile territory. 2. A man with demon possession tendencies is hurting himself and is living in the tombs. This is a place created by the community for the safety of the community. 3. Jesus arrives on the scene and demons recognize him as the Son of the Most High God. 4. The demons want to leave Jesus' presence and Jesus allows them to leave the man and go into the herd of swine that is nearby. Jesus accomplished two purposes: the swine were killed and the man was healed. The resulting consequence produced fear in the community. Jesus was asked to leave and the healed man wanted to go with Jesus, but Jesus said no. Jesus sent him to family and friends to be the first missionary to tell others of his mercy. The herdsman carried the news about what Jesus had done.

Ched Myers, author of *Binding the Strong Man*, takes a non-traditional, social political view of the passage that is described as Jesus' Construction of a New Social Order. According to Myers, "Jesus encounters immediate resistance in the form of a demoniacally possessed man. Through verbal confrontation and powerful exorcism he overcomes this challenge, provoking amazement and publicity" (Myers 1988, 192). When Jesus got out of the boat, a man with an

impure spirit came from the tombs to meet him. This man lived in the tombs, and no one could bind him anymore, not even with a chain. Myers let us know that, “Immediately upon his arrival on “the other side” Jesus is confronted by a demon. In it Jesus inaugurates another round of powerful symbolic action in his ministry of liberation” (Myers 1988, 190). Jesus came to make a change in the life of those who were set apart from community. Myers makes the following points on how the non-traditional perspective connects with the project concerning the knowledge, attitude and actions of parishioners about the mentally ill:

> The demoniac’s dwelling among the tombs and the presence and role of the pigs symbolize impurity according to the Jewish cultural code. The King had to coerce the Jews to live there because the area was unclean; it was built on the site of a graveyard. The demon’s salutation to Jesus has Gentile overtones. Jesus is named ‘Son of the Most High God. In the most dramatic exorcism in the Gospel, Jesus puts an end to the efforts by the demons, also known as the powers, to “name” him, by turning the tables. (Myers 1988, 190-191)

“Then Jesus asked him, “What is your name?” “My name is Legion,” he replied, “for we are many.” And he begged Jesus again and again not to send them out of the area” (Mark 5:9-10 NIV). According to Myers, “Jesus obtains the name of the demon, ‘Legion’ which has military ties referencing a division of Roman soldiers. The term used for herd was inappropriate for pigs, who do not travel in herds, but was often used to refer to a band of military recruits. He dismissed them which connotes a military command and the pigs charged into the lake as suggesting troops rushing into battle” (Myers 1988, 191). The tables were turned and the demons went into the pigs which rushed into the lake and killed themselves.

As found in the discussion of the traditional perspectives by Perkins and Lane, Myers now opens the door to exorcism in addition to the “social

psychology" of mental illness. Myers notes that "demon possession in traditional societies is often a reflection of 'class antagonisms rooted in economic exploitation or escape from oppression" (Myers 1988, 192). The man was living in a place that set him apart from others and the circumstances allows us to provides some clarity on how the mentally ill were viewed in relation to the time. Myers informs us that, "Not denying that oppression can generate mental illness, a socio-literary interpretation reads the exorcism more broadly as a public symbolic action, to satisfy the larger community" (Myers 1988, 193). The community that he once belonged to has now ostracized him and demons are present.

Since the community has assimilated to his prison and no longer desires that the man fit into their community, what has become of the unconditional love of the community and the church? Where does the person that is different belong? Because the man does not exhibit the traditional behavior of others, and when others do not see their image of God when they look at the man, the man becomes the demon that everyone is now afraid of. Losing one's identity becomes more than losing a piece of paper that identifies you, it is actually losing who you are within yourself, to something that you do not even understand. When one is ostracized from society and provided no aid, the end result is the same: the self-fulfilling prophecy is realized and you are now the demon where crazy and insane people are not of mainstream society, but must be tolerated. Myers describes the reality of living with mental illness in the tombs.

> The story describes the situation of the sick man very vividly, repeating the gruesome words, chains, shackles and tombs. The man is violently out of

> control; he behaves like a wild animal and even injures himself. The people's efforts to keep him chained and shackled are in vain. He continues to desecrate the graveyard, a sacred area, living among the tombs, the space of the dead. (Myers 1988, 190-192)

Today, demon possession or demoniac oppression for the average person is not an everyday occurrence of life, but living with a mental health concern is. The social environment where one lives is a major contributor in the person's mental well-being. Myers contends, "This socio-literary strategy shifts from the symbolics of repudiation to the symbolics of reconstruction. Jesus' healing, feeding and journeying articulate the forging of a new order in the very midst of the old one with which he broke" (Myers 1988, 186).

The *Global Bible Commentary* as written by Hisako Kinukawa, is a non-traditional perspective with "a post-colonial and post-imperial discipleship in line with Jesus' teaching" (Kinukawa 2004, 368). Being poor has now become a label of oppression. Poor now takes on the meaning of being socially unacceptable. According to Kinukawa, "The possessed or mentally disturbed man symbolizes disable people unable to maintain proper social relations in their community" (Kinukawa 2004, 369). Both Myers and Kinukawa see a man that does not relate to society because the present environmental situation has now become oppressive due to the views of society. Kinukawa goes on to point out that:

> The social and economic implications are clear; the man has lost all relationship with his family; he has been cut off from all human contact; he feeds himself by begging from the people who visit the tombs to venerate their dead ancestors and relatives or is taking the food brought for the dead. Though living, he is treated as dead. Physically isolated from his kin, totally marginalized from the community and considered unclean, he is socially alienated as "other." In sum, he symbolizes society's outcasts. The man's abnormal behavior might be his way of struggling with harsh circumstances. Or the man might represent someone with a mind

> occupied by demons, someone who has internalized the collective anxiety of a community under social, political, economic or religious oppression. Jesus' exorcism can be read as a politically symbolic action against severe exploitation that prevents people from living decent lives. (Kinukawa 2004, 369)

The mentally ill are society's outsiders, throwaways or recluses. We avoid, we segregate, we isolate, we form opinions and we dictate how those who are somehow different from us should exist by imposing the values of society before taking a deeper dive.

Whereas the *New Interpreter's Bible Commentary* for the Gospel of Mark by Pheme Perkins and *The New International Commentary, The Gospel of Mark* by William L. Lane has been helpful, and Ched Myers book, *Binding the Strong Man*, has been insightful, along with the perceptive insight found in the *Global Bible Commentary* by Hisako Kinukawa, I take my point of departure from *True to Our Native Land: An African American New Testament Commentary* of Liberation by Emerson B. Powery which is more perceptive and relevant. The commentary titles this passage of scripture: Exorcism on the Gentile Side: The Crossing of Social Boundaries.

Based on the passage, "This is the first occasion in which Jesus, the Jew from Nazareth, enters Gentile territory. As he begins his mission in Capernaum, his first act in Gentile country is also an exorcism" (Powery 2007, 130). Jesus now embraces the gentiles and an exorcism that leads to a better quality of life. Powery goes from crossing the social boundary to naming the demon that has taken resident. "The pronouncement of the name 'Legion' makes explicit what had only been festering underneath. The possessive demonic is named Legion

which is the common word for a Roman military cohort of about five-thousand soldiers" (Powery 2007, 130-131). The name along represents many and organized power.

What does Jesus do when he comes across such power? Based on Powery, "Jesus allows the drowning of the demons in the sea" (Powery 2007, 131). With that destruction comes a new freedom for the man and the community that is not welcoming. Crossing social boundaries is a difficult task.

> The reaction of the villagers is odd. Why are they not pleased when they 'witness' the new condition of the man? Do they prefer the man's constant disturbance and the legion's disruption? Their fear is pronounced, people fear the man and the disciples are 'afraid' of Jesus. The narrative shifts, at this point, as Jesus becomes a person to fear as well as a person to respect. It appears that the community prefers the man's constant disturbance and the legion's disruption. (Powery 2007, 131)

The people are still fearful and crossing social boundaries can be as painful as when the man was imprisoned and engaging in self-destruction.

Powery lets us know that the change was dramatic for the man, the community and power structure. The man was clothed and is now in his right mind. Jesus had crossed over into Gentile territory which was now crossing the line that had been drawn by this community.

> Before Jesus leaves this territory, at the request of its "citizens," the spiritually and emotionally stable man requests one thing, to remain with Jesus. One cannot blame the man for not wanting to stay among folk who wish to send away his restorer. One cannot blame him for not wanting to stay among people that cannot see when oppression is thrown off for their own good. But, Jesus denies the request. Although the text provides no rationale, Jesus may have wanted to seize this opportunity to begin his cross cultural mission. (Powery 2007, 131)

Jesus sends the man back to his people to tell others how much the Lord has done for him. Jesus now seized this opportunity to let the community know

that he came to do the work of his Father for all people and isolation and oppression was no longer the order of that day. According to Powery, “This formerly possessed man announces throughput Decapolis the news of victory over the forces of evil, representing Satan’s power and the power of Rome” (Powery 2007, 130-131). Plus, the man was representing the power of the grace and mercy of Jesus.

Summary

In the traditional and non-traditional commentaries, the major points of the biblical passages selected are the same or similar. However, the crossing of social boundaries is a representation of change that empowers those in a position of weakness. The crossing of social boundaries is a representation of a man crossing over from an imprisoned life that is socially acceptable to freedom and acceptance that he now must fight for. The crossing of social boundaries by those identified as unacceptable is a discussion of power. If the action of others takes one out of the normal, into the abnormal; from freedom to prison; then we cross the social boundaries of equal acceptance. The above points represent Jesus at work in the lives of all people. Society tells us we must remain where one is accepted. Society’s expectations do not allow or tolerate non-compliance for any extended period of time. If one moves into the unacceptable realms of expectation, we no longer allow ourselves to see the person and the needs of the person. Society’s focus becomes what we see in the imprisoned person and what they have become. We are all born in the image of God, yet we live on the

edge of acceptance and non–acceptance because of the struggle to fit into society.

Today are we preparing for another exorcism of the mentally ill or are we seeking to represent the actions of Jesus in aiding restoration to the mentally challenged? Jesus has opened the door and change happened for the man and community. The demons did not stay with the man and Jesus was able to heal the man and start the healing process within the community. Jesus acceptance offers the opportunity to not only survive, but to thrive. If a person is different, then they are placed into a category that leaves them abandoned and alone with their suffering because of social acceptance. It took the restoration of the man and the actions of Jesus to change what we believe and what we accept. Today, a 'new normal' requires that we transform our hearts and minds concerning the mentally ill so that the person is still accepted by society.

Theological Foundation

Orobator in *Theology Brewed In An African Pot, states* "Theology is a composite of *theos* and *logos*. Both words come from the Greek language: *theos* meaning God and *logos* meaning word. Put together they mean our word on God and about God. Simply defined, theology is our study of God" (Orobator 2008, 2-3). My project, which focuses on the mentally ill, is grounded in a Black Theology of Liberation. Cone states in *A Black Theology of Liberation* that there are many factors which shape the perspective of Black Theology; one of which is being black and oppressed and another is belief in Jesus Christ. Cone argues, "Black

theology is Christian theology because it centers on Jesus Christ. There can be no Christian theology which does not have Jesus Christ as its point of departure" (Cone 1986, 5).

Cone shapes his point of engagement on a society where persons are oppressed because they are black, and then shows how Christian theology that has now become Black Theology is the roadmap in the black church and community. Cone states, "There can be no theology of the gospel which does not arise from an oppressed people. This is so because God is revealed in Jesus as a God whose righteousness is inseparable from the weak and helpless in human society. The goal of black theology is to interpret God's activity as related to the oppressed black community" (Cone 1986, 5). My project is grounded in Black Theology, with the oppressed including those who suffer with mental illness challenges.

Moreover, Orobator lets us know we should not speak of defining theology without also defining Christology. Orobator tells us, "Our word about God or theology would be seriously deficient if it ignored Christology. Christology is the theological study of Jesus Christ. As Christians, we recognize Jesus Christ as the center of our Christian faith; we profess our belief in God, in and through Jesus Christ: 'I believe in Jesus Christ, the only begotten Son'" (Orobator 2008, 67). Theology takes on different meanings as we add our life experience to what we know and believe. Both Cone and Orobator include suffering and oppression in describing their definition of theology. Cone says, "Black theology is survival theology. It must speak with a passion consistent with the depths of the wounds

of the oppressed. Theological language is passionate language, the language of commitment, because it is language which seeks to vindicate the afflicted and condemn the forces of evil" (Cone 1986, 18). Orobator says, "Black theology is survival theology" (Orobator 2008, xx). The black church and black community has to find their passion in addressing mental health or those who are afflicted will continue to struggle for acceptance.

The lack of action of the church membership leads us to believe that there is a different definition of theology for the mentally sick. With the black community being an extension of the black church, in allowing the mentally ill to participate in full acceptance of their 'new normal' within the context of church and worship, would say that even the mentally ill are full participants of the church and belong to the same God and Jesus. According to God and his Son Jesus, everyone is entitled to unconditional love. In the AME church we experience unconditional love at a distance and are still working on acceptance. According to Cone, "Black theology rejects the tendency of classic Christianity to appeal to divine providence. To suggest that black suffering is consistent with the knowledge and will of God and that in the end everything will happen for the good of those who love God is unacceptable to blacks" (Cone 1986, 17-18). Therefore, it should be unacceptable when attempting to embrace the mentally challenged.

The black race finds its identity in being made in the image of God; yet, the search for identity and purpose for the black race happened after slavery destroyed what was known as the black community. We start to question the

purpose God has for a black life when every wakening day revolves around anguish and distress. Thus Cone argues, “The task of black theology, then, is to analyze the nature of the gospel of Jesus Christ in the light of oppressed blacks so they will see the gospel as inseparable from their humiliated condition, and as bestowing on them the necessary power to break the chains of oppression. This means that it is a theology of and for the black community, seeking to interpret the religious dimensions of the forces of liberation in that community” (Cone 2015, 5). Living in that reality allows God intent and promise to surface, even when some people are diagnosed with a mental health concern.

When does Black Theology, grounded in the oppression of others rise to a level that opens the eyes of the church to understand mental health as another issue of oppression? Cone says,

> Creative theological reflection about God and God’s movement in the world is possible only when one frees oneself from the powers that be. The mind must be freed from the values of an oppressive society. It involves prophetic condemnation of society so that God’s word can be clearly distinguished from the words of human beings. Such a task is especially difficult in America, a nation demonically deceived about what is good, true and beautiful. (Cone 1986, 21)

The pain and humiliation experienced by those who suffer with a mental health disorder is crippling to the point that it results in isolation from the church and community. The mind, the ministry of the black church, and the acceptance of the black community, must be freed from oppressive thinking to embracing new ways and new actions that result in change for all people. Cone says *in God of the Oppressed*, “But, there is hope for liberation in the “not yet” found in a vision of a new heaven and a new earth. This simply means that the oppressed have a

future not made with human hands but grounded in the liberating promises of God" (Cone 1997, 145).

According to Hayes, in *Forged in the Fiery Furnace*, "African American spirituality is a result of the encounter of a particular people with their God. It is their response to God's action in their history in ways that revealed to them the meaning of God and that provided them with an understanding of themselves as beings created by God" (Hayes 2012, 2). God and spirituality serve as the glue that held the black race together. The spiritual connection within the black community of faith gave the black race the will power to continue on and not stop; they had a vision. According to Hayes, spirituality is a direct result of God in our life. Hayes contends,

> There is a spiritual history written in the blood, sweat, and tears of countless foremothers and forefathers who died under the lash, were sold as commodities, were treated as less than human beings, but who struggled and survived despite and in spite of all forces arrayed against them." That struggle and perseverance defines their definition of theology. (Hayes 2012, 3)

That same vision and passion must find itself into the AME church, as well as all black churches.

How does life affects the definition of theology, especially when we each have a different story? In *Theology Brewed In An African Pot* by Orobator, he states, "theology develops within the particular culture and context of community that attempts to speak to the reality of daily living" (Orobator 2008, 153). Daily living for those with mental health concerns can still be a form of imprisonment. The ability to live is determined by the level of acceptance within the community. Theology is defined as "the person's faith seeking understanding, love and hope

in living life" (Orobator 2008, 5). From the Old Testament in Joshua which says to the people, "Be strong and courageous. Do not be afraid; do not be discouraged, for the LORD your God will be with you wherever you go" (Joshua 1:9 NIV); to the New Testament where Jesus heals the demoniac, "Jesus did not let the impure spirit speak, but said, "Go home to your own people and tell them how much the Lord has done for you, and how he has had mercy on you" (Mark 5:19 NIV); the mentally ill is looking for themselves in the word of God. The mentally ill may wonder does the definition of theology for the African American race still includes the lived experience of those who maybe slightly different? The response has to be yes because every life stands because of the love of Jesus and because Jesus is still healing and restoring. If this was not so, our point of departure would be flawed.

In *Virtues and Values: The African and African American Experience* by Paris, theology is defined as, "Human beings at the center of a sacred cosmos in which they are expected to assume immense responsibility for the preservation of its unity. In return for their devotion and faithfulness, humans can expect the protection of both the divinities and the ancestors from a variety of unfriendly cosmic forces" (Paris 2004, 6). In the beginning, God created the heavens and the earth (Genesis 1:1 NIV). Then God said, "Let us make human beings in our image to be like us." (Genesis 1:26 NIV). The theological foundation guides us in experiencing and knowing the triune God: the Father, the Son and the Holy Spirit. Within the black church and community, we know and experience a God that is almighty, all-seeing and universal. Paris believes, "Much of African

thought, including that of theology and ethics, arises out of the problems of our daily experience, and it is pursued for the purpose of discovering practical solutions for everyday problems. In short, African theology and ethics are practical theology in the service of the community's well-being" (Paris 2004, 9).

Cone lets us know that "the first task of theology is to recognize that truth is not contained in words. Truth is found in the dynamic of the divine human encounter in social existence wherein people recognize the connections between historical struggles and ultimate reality" (Cone 1975, 136-137). Therefore, the intentional isolation of those who are diagnosed with a mental health concern is not good for the community. People thrive in community and it is in community where our differences are not treated as flaws that cannot be overcome. Psalm 139 also speaks to the creation of all of God's children. It states, "God knew the plans for you before you were knitted together in your mother's womb. I know I am wonderfully made. Nothing was hidden from you when I was made. God you saw my unformed body and all the days of my life ordained for me were written in your book; written in God's book" (Psalm 139:13-16 NIV). The community's well-being is never out of sight of the Triune God. We need the AME church and other black churches to be active participants in God's vision for all.

The mentally challenged person was conceived in community, born into the faith community, but along the way while living life, something began to change. The black church, black community, and the belief that God is in the midst of all changes has been misplaced or forgotten. Paris states that "moral values are defined by all of what you believe and what you are with a focus on

God, community, family and person; all four being interdependent and one cannot function without the other" (Paris, 2004, 2). Often times we do not know why there are chemical imbalances, anxiety disorders, debilitating addictions or why the person is bi-polar or what causes the person to be paranoid schizophrenia, manic depression or suicidal. But, we do know that through life's journey, the church and the community is not embracing and the person is pulled away from community to a place of isolation because of the illness. We as a black race know God and we know that throughout the advancement of this race God has guided us through all adversities. Our belief is so strong in our God that we place all of our hope and trust in this God who guides our point of departure. Yet, in the church, it is difficult to see God in the actions surrounding those with mental health concerns.

Orobator tells us, "God relates to us in love; to forgive and to save us. The whole Bible, particularly the New Testament, bears witness to this truth. If fact, we can say that grace represents the fundamental message of the Bible, from creation through the life, passion, death and resurrection of Jesus Christ, to Pentecost" (Orobator 2008, 54). For the mentally ill, Jesus has made provisions for a life that does not require isolation and has created ways in which the church community should be able to take a more active role in the 'mental wholeness and mental wellness process'. For the mentally ill, the struggle to overcome the stigma of the illness is sometimes so overwhelming that a person wants to make the same request as the demons, "Jesus do not torture me" (Mark 5:7 NIV). But

through our faith and spiritually, we know that there is a God that will take care of our needs and love us.

Summary

In summary, Cone claims “Black theology is the theological expression of a people deprived of social and political power” (Cone 2015, 15). God loves all people, but for the mentally ill, love from others is not enough to overcome the fear of others or fear from others. For the mentally challenged, sometimes the love from church members and the community is the tomb, the chains and the prison. The power of God is ever present, but because we all have free will, decisions are not always made with the best interest of everyone in mind. We believe as a race of African American people that nothing is impossible with God. When God is in the midst of the struggle, in the midst of the battle, the faithful will survive. God is all powerful and has control over impure spirits. God controls what happens in the life of the believer. In a very real way, that is no different than the way God shows up in the life of the mentally ill. The journey, liberation, change and acceptance is long and rugged, but God will prepare one for the journey and its outcome; as long as one keeps God first in their life. The grace and mercy and love of Jesus is renewed every day. Yet, love does not always prevail in accepting the mentally challenged. Orobator reminds us that, “God acts within freedom, never against it. God’s grace does not compel or coerce us” (Orobator 2008, 56).

Historical Foundation

According to Floyd-Thomas, “The Black church has been the Black community’s foremost means to overcome the cumulative dehumanization of slavery, segregation and social injustice” (Floyd-Thomas 2007, 4). In the historical foundation of the African Methodist Episcopal Church (AMEC) is the brutal history that shaped a group of people that witnessed a “before God” journey that shaped the good, the bad and the ugly. This journey involves a group of people looking for the savior to protect and mold them within the reality of slavery, oppression, racism, separation, rejection and the quest for religious acceptance. This section will cover how the churches’ past paved the way for freedom and restoration; including the role the pastor, church and community played in shaping the future of a group of people. This section will also unpack how a group of people, seeking a place to worship freely, evolved into how to adjust to a “new normal” within the church when diagnosed with a mental health disorder. George Singleton wrote in *The Romance of African Methodism* in 1952, “The very idea of former slaves resenting social injustice to the extent that they break with the old organization is startling. They were indeed daring and heroic” (Singleton 1952, 24). Today, we still need the church to be daring and heroic.

Looking to the past, slaves who no longer had masters, sought to create a way to freedom with a God that was for all people; where they decided to not embrace their present condition of enslavement of body and mind. Floyd-Thomas wrote in *Black Church Studies An Introduction*, “In this fashion, slave religion soon became the means to galvanize people of African descent into a more

cohesive community based on their religiosity as well as their race" (Floyd-Thomas 2007, 6). Out of an intense desire for freedom, the African Methodist Episcopal church was born out of the Free African Society in 1787; and through struggle and perseverance, became her own denomination in 1816. George Champion wrote in *The Pastor's Manuel For The 21st Century, Volume 1: Toward the Orders of Deacon* that,

> The Free African Society allowed the founder, Richard Allen, to focus on what was most important for the people at the time. Much of the success and attraction of the Free African Society was its independence and responsiveness to various community needs. Dues paid into the Society were applied to burial expenses, sick relief, and care for widows and orphans. Early on, the members of the Free African Society valued the importance of collective work, cooperative economics and communal as well as individual responsibility. (Champion 2002, 186)

The then and now are quite different for the AMEC. With so much brutality and oppression that shaped the past and designed the future, how did the church grow and survive as a great institution for over two hundred plus years without taking a closer look at mental health challenges within the church?

Today, we help causes, but do not take the lead in seeking real change concerning mental wellness. Floyd-Thomas stated,

> In the years after slavery was abolished, the historic Black church became the most important institution among African Americans other than the family. Not only did churches fill deep spiritual and inspirational needs, they also offered enriching music, provided charity and compassion to the needy, developed community and political leaders; and did all of this free of white supervision. (Floyd-Thomas 2007, 18)

Historically, the black community's belief in God, Jesus and the Holy Spirit was the catalyst, the glue for the AME church that held a broken people together to achieve the plans God laid out. Presently, there appears to be something missing

or the glue, the church, has lost her cohesiveness, and the lives of some that are marginalized have been pushed aside or hidden so that “social survival” does not appear real nor readily available.

The AME church managed to grow, move forward and survived. But as it appeared on the surface, this happened only by continuing to address the immediate survival needs of church members and it gave the impression of paying minimal attention to mental health disorders. A serious evaluation by the AME church on how to aid those impacted by debilitating mental challenges is now needed. According to Paris, in *The Social Teaching of the Black Churches*, “The Black church is in some sense a ‘universal church’, claiming and representing all Blacks out of a long tradition that looks back to the time when there was only the Black church to bear witness to ‘who’ or ‘what’ a person was as they stood at the bar of the community” (Paris 1985, 8). What is also amazing is that when the time came for the church to look for help to address mental disorders, she did not embrace outside resources by partnering with other organizations. The problem grew stronger in silence as people with mental disorders were isolated or separated within community, as if the church was in hiding.

The purpose of my project is to discover the knowledge, attitude and actions of parishioners about the mentally ill in the Cleveland District of the North Ohio Annual Conference. In gathering data, “Blacks have always felt themselves to be the victors in a moral struggle” (Paris 1985, 61). Which makes me wonder if we as a race found peace in ignoring the problems of mental health imbalance?

Through presentations and stimulating conversations about mental health problems, there was never the statement, due to extreme emotional duress and stress, that we started a mental health ministry years ago; and today we need to revamp it. There was only silence. I knew my project had to start with me, my family, my church and when I began my pastoral journey in November, 2008. During this time period, I had to make an adjustment to earnestly see my brother's 'new normal', which was completely different than all that I thought I knew. Plus, there was still a need to reevaluate the historical journey of the founding fathers of the church.

What has my church, the AME church, done in relation to helping people work through mental health disorders? Where is the Pastor when it comes to championing the cause of the mentally challenged? Neighbors informs us in *The African American Minister as a Source of Help for Serious Personal Crises: Bridge or Barrier* that,

> The African American minister occupies a truly unique place in the conceptual scheme of helpful sources. More than any other help resource, it has been argued that Black pastors are uniquely positioned to play two critical roles. The first is that of a primary mental health treatment source. The second role is that of a gatekeeper and referral source to specialty mental health care. (Neighbors 1999)

Are we there yet? When the black church is believing that it is not in conflict with what society is expecting, what the black community is demanding, or is saying to those who are suffering, that the black church is not in touch with the needs of the people, we can answer yes to the question. Until then, the lack of church involvement infers that the black church may not be relevant. When does the black church start the conversation so that the church can move

forward in acceptance and not remain silent on those with mental health issues? The AME churches in the Cleveland District are there for the homeless, alcoholics, drug addicts, gambling addicts, single parents, those who are hungry, those who are grieving, those who battling cancer and senior citizens struggling to age in place. But the support systems are incomplete if mental health issues, such as bi-polar and paranoid schizophrenia, are not added to the list.

Historically, how far have we come in embracing those who are surviving with mental health challenges within our congregations? According to Jackson, in *For the Souls of Black Folks – Reimagining Black Preaching for 21st Century Liberation*, "Historically Black preachers have served as interpreters not only of Christian scripture, but also of the Black experience in society and the overall life experience in the Black community" (Jackson 2013, 30). Mental health issues are not new to the black race, but what is certainly questionable is how the AME church reacted to and prepared for what is now a mental health crisis and what the church is doing to combat the residual effect of 'no action'. In the past, the black preacher and the black community have been in the forefront for morality issues and social change. According to Paris, "persons are born into a ready-made world that constitutes the paramount conditions for human development. Specifically, these conditions designate the moral ethos of the society and they represent the society's most basic set of shared values" (Paris 1985, 57). Morally, the black church missed the mark of helping all people to thrive.

When we cease to open our minds to not only the people differences, but close our minds so that all we see, experience and use as barometers are the

things of the past that are no longer relevant; then we cease to move forward. From the starting point of the yellow fever epidemic for the Free African Society to the mental health crisis of today, the AME church does not look the same. The change between the church's efforts in the past and her efforts of the present, shows that the AME church does not clearly embrace a "new normal" concerning mental illness.

People seek out the church for unconditional love and encouragement; and the community provides a sense of strength and empowerment. For a lot of people, the church has been the community where 'living life' takes place. The sense of community found in the local church was nurtured from childhood and for most members; the church becomes the safe place to thrive or fail. The church is the stable structure of the neighborhood that values and loves you unconditionally, even though the struggle has been long and hard. Paris lets us know that,

> Blacks have sought to change their environment. Since victimization implies a condition of passivity, acquiescence, and forced obedience, the new breed of scholars has been diligently demonstrating that blacks have functioned in every historical period as agents of change in spite of the extreme environmental constraints upon them. Their capacity to find alternative ways of thinking and acting in such ways in such situations evidences the tenacity and resiliency of the human spirit in encounter with life-threatening conditions. (Paris 1985, 3).

But in today's society where the preacher has become all things to all people, the preacher has to be careful in rendering assistance that could cause more harm than good. It is difficult to understand the role of the church when the church has existed for over 200 years, and is so out of touch that the same support system offered to those with a mental health concern is the same

support system that is offered to everyone. In some cases that is equivalent to 'you should meet with the Pastor'. One size does not fit all and the church must become intentional about addressing mental health. Social isolation limits the person's world view of acceptable and desired behavior. The pastor is the leader, and in most cases is not equipped to deal with evaluating and guiding others on mental health concerns. According to Neighbors,

> Using data from the National Survey of Black Americans, which explored the role of African American ministers and the help offered to those seeking assistance with serious emotional problems. The paper describes the specific types of help offered by ministers and whether help seekers are satisfied with that help. The most common type of help offered by ministers is related to religious activities and socio-emotional support. (Neighbors 1999)

Again, more effort is needed to educate and develop a plan for all members, which include the mentally challenged.

Summary

Black people are a faithful people to the teachings of the Bible. They are waiting on and watching for God's direction and struggle with the ever changing and conflicting social issues in their lives. According to Paris, "There are conflicts in the moral thought of the Black church which have centered on loyalties to the functions of serving the needs of the race, serving the needs of God and implementing the pastor's vision" (Paris 1985, 74). Acceptance, by the church, of the mentally challenged has become a discussion topic within the church and the church is now in a state of vacillation between what she is doing and what she needs to do to stay relevant in dealing with this issue. According to Jackson,

“Serving historically as the mediators/interpreters for Black communities, Black preachers have played a powerful role as the gatekeepers of the Black collective accounts, especially for Black Christians and the moral culture of the church” (Jackson 2013, 23). As members of the body of Christ, one would hope and expect that the church’s resolution would fall on the side of doing what is right for the person.

The church is a familiar place; yet it is not so familiar. The church is where one will find a loving environment; yet there are times when the church does not love unconditionally and is not a safe place to weather a storm. The church is becoming the place of discomfort where the voice of the mentally hurting is not heard. Madipoane Masenya stated in *Exiled in My Own Home: An African-South African Perspective on the Bible in the Africana Bible* says, “I write from Africa, my home continent. Africa is however, a stranger in my life, as it cannot participate as an equal partner. More specifically, I write from South Africa, my home country, also as a stranger. I therefore do biblical scholarship as one ‘exiled’ at home” (Masenya 2010, 20-21) The world of those who are mentally challenged is a world of ‘exile at home’ where they exist in a strange place that we call the church of God. The church in which the person was raised, taught the word of God, received the word of God, lived the word of God, is a different church once there is a rumor or diagnosis of mental illness. In our present time, a diagnosis of cancer will generate an embracing church family, but a mental illness episode will get one ostracized.

The progression of a mental health condition can change a person to the point that the person never leaves home because loneliness at home is more tolerable than isolation in the church and avoidance by the community. But what is worse than the mental health condition that the person is dealing with is knowing that acceptance by the church was theirs, until life happens. The person that was once a believing and contributing member of the congregation, is now rejected by the church. Yet, the question still remains, what should I expect from the pastor? Neighbors challenges us to look further,

> While no one would dispute the tremendously important role that Black ministers play in meeting the mental health needs of African Americans, important questions remain regarding the specific functions of Black ministers when they are contacted by someone in the midst of a serious emotional crisis. We know surprisingly little, for example, about the specific types of help offered by Black clergy during counseling sessions. To what extent are Black ministers able to recognize symptoms of depression or suicide risk? No one, to our knowledge, has been able to document how Black pastors operate with respect to referrals and whether these factors vary as a function of the type of problem or diagnostic category. Are Black ministers prone to refer church members to a mental health professional, or are they more likely to counsel the individual themselves? (Neighbors 1999)

The black preacher and the black church are moral agents and are God's representatives in the faith walk of a person dealing with mental health concerns. The faith community must come together to discuss strategies and move beyond the crippling fear of the unknown and work to restore the individual back to wholeness.

CHAPTER THREE

REVIEW OF THE LITERATURE

Where is the mental health wing in the church on Sunday Morning? Where is the pew located where the people who do not look and act normal sit? Where, in the list of ministries in the church bulletin, are the meetings for the support group for those who have family members diagnosed with a mental health condition? Where in the church is one supposed to go for resources on mental health? Searching for assistance and support within the AME church was a futile effort and very little was found. Mental health resources are elusive in the church; the place that is supposed to be the hospital for the sick. Therefore, one concludes, the church, like all other hospitals, tucks away the help for the mentally ill in the farthest wing of the farthest corner of the hospital. If there are any resources for the mentally ill in the church, the search of literature specially written by AME church members becomes a deterrent because written documentation shines the spotlight on that person and avoidance of the spotlight is where that person finds peace.

In all of the readings for this paper, from the scriptures, to the books, to the articles and statistics, we are surrounded by people coping with mental illness. Families struggle because of those impacted by the disease and the ongoing presence of the continual nagging question, ‘Am I crazy?’ Do I need a mental health checkup? Am I already ostracized from my family, community and church and just do not know it? Am I living or just existing with this illness? Does

my brother's diagnosis mean that someone else in the family already has a mental illness diagnosis? Frohlich and Stebbins argued in *12 States Struggling with Mental Illness,*

> Despite the mind's importance to an individual's well-being, mental illness is often poorly understood and subject to misperceptions by the general population, family, co-workers, doctors, government officials, and even those who suffer from mental illness. Partially, as a consequence, just under one-third of individuals with serious mental illness — defined as diagnosable mental, behavioral, or emotional disorders that result in functional impairment — are untreated in the United States". (Frohlich and Stebbins 2016)

The focus of my project is to discover the knowledge, attitudes and actions of parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME). The purpose of this chapter is to acknowledge mental illness as a disease; to aid in acknowledging the various attitudes concerning the disease and to review and evaluate ministries within the church that aid the person. In reviewing the various literatures, listening to mass media, evaluating local, state and federal resources, one can see the church is trying to join the conversation, but one would have to wonder what would really happened if the church showed up in a committed way? Today, if the church joined the conversation, it would need to catch up in order to be an advocate and leader in the black community on mental health. For the church to stay at 'arm's length implies that the church continues to live in denial of a disorder that impacts the life of so many people.

Mental Illness – Definitions

When was the first time that someone jokingly said the word ‘crazy’ in reference to you? As one ages, one begins to wonder whether there is some truth within the joking when you walk into a room and cannot remember why you are there; you misplace something that is very important to you; when you do not mind being alone or people start to make allowances for you and so do you. Am I crazy? Moving forward, we must define mental illness so that we can see if there is any truth in the observations and the conclusions drawn by others. The National Alliance on Mental Illness states,

> Relentless stigma accompanies mental health conditions. From the words we use—like "crazy," “cray cray,” “psycho,” “nuts”—to hurtful jokes about people who live with mental health conditions. Stigma surrounding mental health in the Black culture is deeply-rooted and very difficult to overcome. But there is no shame in having a mental health condition. The true shame is not getting the treatment you need to have a good life. (Bryant 2018)

Yet, those who are affected, are overly cautious and very careful and sometimes over think the why when sharing mental health issues because once spoken out loud, whether it is true or not, the labels attached to a person’s mental well-being, will start to stick.

In searching for knowledge on what is a mental health condition, it has led to a review of many sources that provide definitions that shape our knowledge of mental health disorders. James Morrison says in *DSM-5 Made Easy – The Clinician’s Guide to Diagnosis*, that

> There are many definitions of mental disorders, none of which is both accurate and complete. Perhaps this is because nobody yet has adequately defined the term abnormal. A mental disorder is a clinically important syndrome; that is, it’s a collection of symptoms, these can be behavioral or

> psychological, that causes the person disability or distress in social, personal or occupational functioning. (Morrison 2014, 12)

There are many conditions that are recognized as being part of the mental illness family. Goldberg (2014) in *American Psychological Association. American Academy of Child & Adolescent Psychiatry* provides descriptions of various forms of mental illness. One of the more common types of mental health concerns include:

> Anxiety disorders: People with anxiety disorders respond to certain objects or situations with fear and dread, as well as with physical signs of anxiety or panic, such as a rapid heartbeat and sweating. An anxiety disorder is diagnosed if the person's response is not appropriate for the situation, if the person cannot control the response, or if the anxiety interferes with normal functioning. Anxiety disorders include generalized anxiety disorder, panic disorder, social anxiety disorder, and specific phobias. (Goldberg 2014)

Daily we hear of those who have been diagnosed with depression, which is listed among mood disorders. “These disorders, also called affective disorders, involve persistent feelings of sadness or periods of feeling overly happy, or fluctuations from extreme happiness to extreme sadness. The most common mood disorders are depression, bipolar disorder, and cyclothymic disorder” (Goldberg 2014).

Mental disorders can carry us in multiple directions, searching for what to do next. Morrison defines psychotic disorders “as a patient out of touch with reality” (Morrison 2014, 58). To be out of touch with reality is to open the door to mental disorders that causes fear within us and those around us. “Psychotic disorders which includes the schizophrenia spectrum and other psychotic disorders are those where the person experience delusions, disorganized

speech, hallucinations, negative symptoms and catatonia or other markedly abnormal behavior" (Morrison 2014, 55).

Goldberg defines eating disorders and impulse control and addition disorders.

> Eating disorders involve extreme emotions, attitudes, and behaviors involving weight and food. Anorexia nervosa, bulimia nervosa, and binge eating disorder are the most common eating disorders. People with impulse control disorders are unable to resist urges, or impulses, to perform acts that could be harmful to themselves or others. Pyromania (starting fires), kleptomania (stealing), and compulsive gambling are examples of impulse control disorders. Alcohol and drug are common objects of addictions. Often, people with these disorders become so involved with the objects of their addiction that they begin to ignore responsibilities and relationships. (Goldberg 2014)

Moreover, Morrison defines "People with obsessive compulsive disorders are perfectionistic and preoccupied with orderliness; they need to exert interpersonal and mental control. These traits exist on a lifelong basis, at the expense of efficiency, flexibility and candor. It is diagnosed more often in males than in females and it probably runs in families" (Morrison 2014, 558). Morrison also defines post-traumatic stress disorder. PTSD will manifest itself in "people who have survived severely traumatic events, both natural and contrived. The events include rape, floods, abductions, heavy combat, prisoners of war, or negative feelings of guilt" (Morrison 2014, 219).

Likewise, a hoarding disorder is something that some people accept as a normal way of life. According to Morrison, "A hoarder's living space becomes cluttered, perhaps eventually filling up completely. Hoarding disorder comprise people who hoard books, animals, food and other items. The disorder begins young and worsens with time, so that it is more often found among older adults. It

is a safety concern and is unsanitary. It appears to be strongly hereditary." (Morrison 2014, 207-208). Another disorder that is becoming more prevalent is alzheimer or dementia. "Neurocognitive Disorder due to Alzheimer's disease that was once called senility, accounts for well over half the cases of dementia. It is also a degenerative disorder where memory lost is the first symptom. Examples include forgetting familiar names or repeatedly asking questions that have been answered or the inability to remember information that was learned within the previous few minutes" (Morrison 2014, 498-499).

Listed above are several mental health disorders. Some are so common, most people do not associate the disorder with a mental health condition. Even though the list of definitions is long, it is not exhaustive, which is an indication of the vastness of mental health issues. In my journey, it appeared that every day new mental health challenges were unveiled to me. Morrison's DSM-5 Made Easy lists "at least 600 codable conditions" (Morrison 2014, 14).

The church is supposed to be a place of help and acceptance for all, but the AME churches in the Cleveland District is absent when it comes to support for mental health disorders. For instance, Neely wrote an article on church shaming,

> Much of how we hear the church address depression fails to take the whole self into account, including people's mysterious neurochemistry and quirky physiologies, their personal histories and traumas, and all the complexities of their souls and lives. Church leaders often leave many chronically ill people feeling like they are not doing enough to help themselves. They also, misleadingly, suggest that one's primary goal in life is to get better —rather than asserting that God is with all, no matter how one is doing, even if it is all one can do to continue to be. (Neely 2018)

It is not easy to live a full life when your daily world is being interrupted with changes that challenge your hold on reality. Within the church, one either sees the disease or the person. Within the church, the person sees the shame and pity in the stares and actions of the members, instead of the love of Jesus. With so many definitions for the illness, one wonders why the disease continues to evolve and the churches' stance on mental health does not change, but remains stagnant. Coleman and Shirley stated in *Too Blessed to be Stressed* the following:

> In a given year, about one in five U.S. adults will experience mental illness of some kind. And though mental illness does not discriminate, African-American adults are more likely to experience serious mental health problems, but less likely to seek treatment, than white folks, due in part to the lasting effects of slavery, segregation, and other forms of race-based exclusion—effects that translate into socioeconomic factors such as poverty, homelessness, and substance abuse which are, in turn, risk factors for mental illness. (Coleman and Shirley 2016)

Maybe It Is You!

DSM-5 Made Easy, The Clinician's Guide to Diagnosis (DSM-5) is the diagnostic and statistical manual of mental disorders, as published by the American Psychiatric Association and written by James Morrison. DSM-5 is the "world's standard for evaluation and diagnosis of mental health and it covers nearly every conceivable subject related to mental health" (Morrison 2014, 5). Today, my brother says, 'I have a mental illness and I am okay'. There are so many different variations of what is defined as a mental disorder that it is very difficult to refrain from placing people that you know in one of the many definitions. There are over 300 diagnosis described in DSM-5. Churches often do

not deal with the reality of her members living with mental illness. Pam Rocker, Affirming Coordinator for Hillhurst United Church in Calgary, Alberta, Canada, argues, “Mental health is often erroneously intertwined with weakness or lack of willpower” (Henderson-Espinoza 2017).

Disconnection or disassociation within church and community places the person in a category for harsh judgment and it is easy to dismiss them. The farther away that person is from being a part of your life, from a family member, a close friend, a coworker, a church member, an acquaintance by association with a friend or family member or someone you see on occasion; the easier it becomes to label and ostracize that person. For example, alcoholism is a mental condition found under the definition of ‘addiction disorder’. Alcoholism is an ‘acceptable mental illness’. The church surrounds you, includes you, is not afraid of you and accepts you for who you are. The church will even say…that person has an illness and cannot control themselves. The Reverend Sheila Evans-Tranum, a counseling Minister at Bridge Street AME Church in Brooklyn, NY, describes the church as a “healing station; not the be-all and end-all of healing, but the place you go either for the help the church can give or to get directed to someplace more appropriate” (Williams 2009, 222). I agree with this statement, but that only works when you are diagnosed with an ‘acceptable’ mental health condition.

Fear and rejection are real in the world of a person with a mental illness. When you look at me, what do you see? Why does fear overtake you if you are alone with me? It is when we, the church, engage what we believe is an

‘acceptable mental illness’ that we are now able to see the person before, during and after the diagnosis and embrace the person for who they are in the midst of the struggle. One may see an acceptable mental illness and say, ‘I am just sick’. For example, I see three different types of alcoholics: the alcoholic who drinks and becomes the life of the party; the alcoholic who drinks and withdraws into themselves; the alcoholic who drinks and becomes a ‘mean and nasty’ person who blames everything on the alcohol. In all three descriptions, one finds the same debilitating disease, but the outcome is different because one sees and reacts differently. Fear does not take over because one sees the person before and during the illness. In all cases, all stages of the illness are accepted by others and the persons are not ostracized. But if a person is bipolar or diagnosed with a psychotic disorder and is on medication, this form of mental illness is not accepted in the church; therefore, the person is isolated and ostracized because theirs is a mental illness that society rejects.

What Took So Long for God to See My Pain?

Here is where I need to talk about God. Where is God during the tears, the heart ache and pleas of deliverance from those who suffer from mental health conditions? Is God present in the sanctuary on Sunday morning? Is God present in the meetings to discuss how the churches’ membership is doing? Is God present when the church’s ministerial staff are evaluating how effective are the church ministries surrounding mental health? Is God waiting in the sanctuary while the person is sitting in the pews waiting for God to deliver them from this

disease? From our African ancestry point of view, from being Black or African American in America, from just living life, we will find God.

Hayes, author of *Forged in the Fiery Furnace*, states “God is one Supreme Being who has many names that is active in all that we do. This God can be male or female; mother or father. This God is seen as both immanent and transcendent, near to those who seek yet distant enough that those who believe must actively search” (Hayes 2012, 15).

Where is God? The answer appears to be confusing when dealing with mental illness. If God is present for all in the congregation; that means God is also present for the mentally challenged. Why does it appear that the favor of God is not fulfilling? To be the person that is called ‘crazy’ is to appear to be a person who is barely holding on to reality and who cannot find God. In *Theology Brewed in An African Pot*, Orobator argues, “Our belief in God develops within the particular culture and context of the community that attempts to speak to the reality of God and the demands of faith for our daily living” (Orobator 2008, 153). The pain of mental illness is daily and God’s protection is provided daily, if you believe in God. When your faith is shaken because of your illness and circumstances, but you still believe that the God we serve does not waiver in his protection; then life is still confusing. If God, and what He means in your life, is lost within the illness, who protects you? In *Canaan Land: A Religious History of African Americans,* Raboteau states,

> The God who created the universe and everything in it acts in the daily lives of human beings to protect them from harm. If people lived good lives and honored the spirits and ancestors by prayer and sacrifice, all would be

> well. If people did evil, or neglected the spirits, they not only lost the spirit's protection, they risk rousing the spirit's anger. (Raboteau 1999, 9).

Where is God when the mentally challenged person needs him?

The authors of these books so clearly define a God that should be equal opportunity and present for all. My God should provide a way for all persons, and not leave the mentally ill person out of the loop. God's arm of protection does not appear to reach out as far as needed to hold on to all people; especially the mentally ill. In *God Talkers Dressed with Inner Vestments: Insanity of Theology*, Young reasons, "God has the uncanny ability to close the curtains of night and open the curtains of day. The north wind of adversity has to go and blow no more as the south wind of joy and enjoyment blows on the situation that has left one in the dark and in the midst of a wilderness situation" (Young 2014, 44-45). God has the ability to heal and bring joy or to bring illness and destruction. Mental disorders does not separate the person from God's grace and mercy and God's presence is in everyday interactions.

In other words, where is God in the midst of the insanity, in the midst of this illness, in the midst of chaos and in the midst of living? Do you meet this God in church? Do you meet this God at work? Do you meet this God at home with your family? Do you meet this God when you escape within yourself? Young, states, "No child of God is exempt from the trials and tribulations of life's journey, God just makes sure that you do not have to settle for 'existing' in life but 'live' a more abundant life" (Young 2014, 44-45).

Black Rage

Grier and Cobbs opens up a discussion in *Black Rage* about the past history of slavery and its impact on mental wellness. Grier and Cobbs state that, “The black man of today is at one end of a psychological continuum which reaches back in time to his enslaved ancestors” (Grier and Cobbs 1992, 24). To carry that type of anger from generation to generation will make for a rocky path to mental wellness and will impact one’s ability to move to the other end of the continuum. Rage is what the demoniac demonstrated and exhibited when he was placed in a prison with no hope of being released. That rage lead him to act out his frustration by becoming what society had already labeled him, a deranged and violent man. Moreover, Grier and Cobbs argue that, “Black rage is the result of our failure, after 300 years, to make the following human values possible: to find an identity, a sense of worth, to relate to others, to love, to work and to create” (Grier and Cobbs 1992, xvi).

The African American race, as a community, shies away from embracing mental illness. Grier and Cobbs states that, “The culture of slavery was never undone for either master or slave. The civilization that tolerated slavery dropped its slaveholding cloak but the inner feelings remained. The practice of slavery stopped over a hundred years ago, but the minds of our citizens have never been freed” (Grier and Cobbs 1992, 26). With that being said, there were no mental health therapists, no support groups and no church members or pastors to love the people unconditionally and reassure them there was a better day coming. Mental help for our ancestors dealing with the atrocities of slavery and aid for

those coping with the lingering byproducts of hurt, anger and shame, taught the black race how to be strong and silent when living through tragedy. The only hope or outlet was praying to God for relief and healing.

In living life with and through slavery, poverty and racism, is there any wonder that we are still imprisoned as a race and not able to seek help? Where do we turn? Grier and Cobbs lets us know the mission of the book has not changed. “The original goal remains unchanged, a clinical handbook illustrating certain unique aspects of psychotherapy for blacks. The gravest danger we see is that unscrupulous people may use psychotherapy with blacks as a means of social control, to persuade the patient to be satisfied with his lot” (Grier and Cobbs 1992, xii-xiii). To be brainwashed into not seeking help maybe one reason church members shy away from addressing mental health disorders. The God that we place our hope in is still here with us; and one day that God will lead us to the promise land that allows us to not bury our pain, ‘our black rage,’ but deal with all of the problems of the past that hinders the Black race from moving forward.

The Pain of God

God promised to never leave us nor forsake us. In providing assistance, within the AME church, to those who suffer with a mental health disorder often leads to being ostracized rather than providing unconditional love, reassurance and freedom. Those suffering a mental health disorder embrace life differences that shape who they are; and find themselves lost in the church, in God’s

presence, seeking wisdom and acceptance. Again, it is within the church, where supporting and working in the life of the mentally ill, becomes perplexing. According to Young:

> People try in vain to handle the challenges of this life by themselves. Preachers who have knowledge of God but not a progressive and working knowledge of God are found dead because of self-inflicted gunshot wounds or in a hotel room overdosing on illegal substances. Pew members who have knowledge of God but not a progressive and working knowledge of God are left in the nighttime experiences trying to find solutions to their hurt and pain. Where is their progressive and working knowledge of God? (Young 2014, 54).

How did the church become the sanctuary of the oppressed? In addition, how did the church miss the signs of hurt and pain? How does the church become the place where all of God's children, sane and insane, joyful and depressed, can come together? Those who suffer with mental illness would say that they are not only oppressed but ostracized and discarded. I also believe that those who are dealing with family members that are diagnosed with a mental condition are also the unintended victims of being ostracized. Young lets us know that "Many persons have lived through difficult times, are going through difficult times or are on their way into difficult times. Yet any of these can be overcome by leaning on a genuine belief and faith in the Holy Spirit, the third person of the Trinity – the Father, Son and Holy Spirit" (Young 2014, 109).

The AME church, the black community, and the person with the mental disorder are asking the same question, where is God? In defining mental illness, we find that we could place ourselves, based on the many definitions of mental illness and many different types of symptoms, in multiple categories of 'crazy'. Yet, we do not do so and some of that hesitation is due to fear. The God of the

oppressed loves all people. So, we now have to try to reason, what makes some people normal, some people not appear to be normal, and some that are accepted as normal.

For the African American community, God is the center of all life. God is the 'go to deity' that is present in the midst of everything that happens. Williams says in *Black Pain: It Just Looks Like We're Not Hurting,* "Even when we face a harsh world well-armed with the weapons of faith, community, and prayer, we must remember that mental illness, especially depression is a devious demon" (Williams 2009, 224). When the demon speaks and Jesus responds; when the impure spirit is bold enough to ask Jesus a question; when the demoniac has retreated within himself because the demons are stronger; when Jesus inquires of the demon; one has to wonder where God was when the demon showed up and took residence inside of the man? Williams says "Unfortunately for so many of us, the example of the church and mental health care professionals working together, or the ability of clergy to not only listen to a member in pain and recommend further care when necessary, is not the norm" (Williams 2009, 218).

Mental illness is not new and there has certainly been an increase in mental health diagnosis based on the multiple definitions. This increased awareness has resulted in attempts to educate the church and the community. Today, there are ongoing conversations concerning where the church is with new ministries and increased aid for the mentally ill community. When we look at the increase of the homeless population, mental degradation as a byproduct of drug addiction, child abuse, physical abuse, the struggles of stress from jobs and

unreasonable expectations, consequences of everyday living; in all of that you find mental health issues and those that believe in God. Based on *Christ On the Psych Ward*, David Finnegan-Hosey claims that,

> Wrecked relationships, alienation from life and fundamental brokenness are all realities that should be understood through the lens of mental illness, God and the church. That is not because mental illness is a sin, but rather because struggles with mental health have put us in deep touch with the brokenness and pain that is a universal realty of human existence. (Finnegan-Hosey 2018, 48)

Pain and brokenness are the reasons our churches are full on Sunday; and the same reasons that our churches are empty on Sunday. The same reason people flock to a particular church will be the same reason a family withdraws their membership. The same reason a community embraces a particular church is the same reason that same community will turn against the place that is supposed to provide help.

What is so astonishing to me is that I never thought my family would be touched by mental illness. Why would that be? Why would flawed thinking allow me to believe mental illness would not touch my family? We refer to people as being crazy so often that it became an everyday word for 'odd but normal' and less of a word of identifying real pain and suffering. My mother would say, "All eight of my children suffer with something wrong with them. All of you are a bit crazy." Now, today, I believe that statement comes with a lot of truth. In *Blessed are the Crazy*, Sarah Lund described 'crazy' as a "slang word that describes a person with a brain disease; or bipolar" that describes the reason some families are more dysfunctional than others and used "crazy in the blood" to describe the

genetic predisposition to suffering from a brain disease" (Lund 2014, v). I believe my mother may have known more than she was disclosing to her eight children.

My brother's mental break brought all of us to this God in a new and intense way; and how this God cares for all of us was brought into question when we prayed for deliverance and healing. Growing up in the church, led all of the siblings to question why the church and church folk are not welcoming to all people? All six of us started to wonder, who did something wrong and what did we miss? All six remaining siblings turned to church, only to find the church was not equipped to handle the problem; nor was the church welcoming. The black church has made tremendous contributions to the community; however there remains what Williams termed, "an unenlightened side when it comes to addressing mental health issues" (Williams 2009, 218).

Lost in the Pain of the Love

According to Hays, "Throughout time, the black church has been the most important social institutions in the Black community. The church has evolved as an agent of mutual help, empowerment and social change and has created opportunities that were nonexistent in the larger society for African Americans" (Hays 2015, 296-312). It is important to talk about mental health in the home and church. If we do not start the conversation, we will never be prepared for the various paths the journey of mental illness will carry us. Therefore, I need to talk about where we are today. Biblical, theological, historical and living life are all rolled into one for my family. Every time there is a mental health crisis or a

progressive diagnosis, there is pain. Feeling pain in God's presence is where Christians are when we come to accept and believe that a loved one is suffering and we cannot help. I could have written the book by Bebe Moore Campbell, titled *72 Hour Hold*. So many times, my family anticipated a "72-hour hold" for just a sense of relief believing that for the next 72 hours my family member would be safe.

In my mind, I have replayed the game of '1000 questions' in trying to assess how we arrived at this point. What signs did I miss? Did someone push him too hard? Was the job too stressful and demanding? Was he having money problems? Was his wife cheating on him? Does his wife's family like my brother? Should I call him tonight? Should I let him rest? Should I make sure my other brother goes to visit? Often I asked the same questions as Campbell:

> When is he going to get back to normal? Lord, please do not let the madness start all over again. He was in a rebuilding phase of his life. He took the first step by taking responsibility for his healing. He took the next step by forming relationships again, becoming more independent, and regaining his autonomy. He had been inching closer to that place called normal. Now normal is lost somewhere in his mind. (Campbell 2006, 38-39)

Every time we had to call the police, for his good, we knew that it was a court order with only a maximum seventy-two-hour hold. Sometimes the hospital stay was long enough to make a difference and sometimes the seventy-two hours was just short enough to let us know that my brother controls the outcome. Seventy-two-hour hold became a household word. I am known by the Rockledge, Florida, police because I have called so many times for a wellness check. My other brother is known by the County Sheriff's office in Rockledge, Florida and

Warner Robins, Georgia for obtaining the court orders and arranging the mental Health evaluation pickups. But in reverse, for 72-hours, we relived the mental health episodes that became known as nightmares.

At first, the family agonized over calling the police, but as time passed, we became upset when we knew that a 72-hour hold would not happen because not enough time had passed and the judge would not grant the order. We became upset and helpless because we witnessed the change in him and we felt so helpless and hopeless. We lashed out at each other because we all wanted each other to understand and see what the other person saw and felt. We each wanted the other person to be just as committed in getting him back to normal. Then, we started to distance ourselves from people who asked questions such as what caused him to lose his mind? Will he hurt me? Does he remember me? Can I talk to him? Those type questions were very hurtful. The 72-hour hold gave us an opportunity to breathe and pray; it gave him the time to see if the treatment was effective.

Lost in the pain of love, is the reason God has brought us to this place and carried my brother to this place. My oldest sister, who has a different father, says there is no mental illness on our mother's side of the family; therefore 'crazy' must come from my daddy's side. Campbell says, "I am damaged, but I am not mentally ill because I am not genetically predisposed to this sort of disease. It must have been his wife that drove him to this disease. The doctor is saying, he has had this ailment for some time and it must run in your family" (Campbell 2006, 28-29). Out of frustration, we all think like that. My family is still trying to

figure out the source of the illness as if it is a disease that has an origin that you picked up from somewhere. My brother's doctor says he has had this disease for a long time, but the doctor stops short of saying that it runs in the family. The doctor's voice and message did imply that there had to be signs and that statement left me with the question of what did we miss?

In *Undoing Crazy*, Colette Winlock states, "In this moment, I think how I've gone frozen, how Mama froze in her life. Oh my God. Is this where it started? Hiding in a forest, reacting to something so big that all you can do is freeze? Stopped – cut off from what you want for your life" (Winlock 2013, 305). When I think about trying to undo crazy, it reminds me of the mother frozen in time, not knowing how to move forward and it reminds me of hiding from life and not living and not disclosing the truth about our mental health. Winlock also stated she was asked the following question:

> So what have you been doing? She did not answer the question truthfully. The real answer was, 'I have been in the house for two days, moving magazines around, playing sad music and eating four-day old leftovers. Been thinking about my childhood, replaying in my mind my father dying, my mother dying.' Deciding that she could not tell anybody all of that, the answer to the question was, 'Nothing much.' Besides I do not want anyone to know everything about me, especially which I drink alone too much. (Winlock 2013, 71)

Even though we ask questions, we really do not listen to the answer or see the person. We live our lives with blinders on and we fail to see the hurt and pain all around us. We want the simple answers because that means we can stay disengaged. Those who suffer with mental illness are lost and there is a need for the church to open their doors and see the lives that are frozen. Someone needs to start somewhere. The AME church needs to develop new ministries. The AME

church needs to provide a safe space to have conversations, to be vulnerable, to change and embrace the ‘new normal’.

According to Williams “When we need something the church cannot offer, we have to recognize that the church cannot be everything to everyone, and it would be unfair and unreasonable for us to think otherwise” (Williams 2009, 223). If expectations of the church should be low, what must be expected of an all-powerful God? How do we change the expectation of the church? For the mentally challenged there is not a different God that guides them when they need to make a decision or just have a conversation. The God of the mentally challenged is the same God that is always present in the church; that God is waiting on us to do something.

Hiding With Mental Illness – Self Diagnosis

Those who know God would love for the church to define that ‘everyday ordinary God’ for the mentally ill. In the church, mental illness is still in the closet, still hiding. But because ‘ordinary’ is driven by life experiences that exist in the context of the person seeking the meaning; a person can get lost in trying to self-diagnose. Those that suffer with any chronic ailment or ongoing affliction are constantly self-diagnosing and asking why. Frohlich and Stebbins tells us that,

> Close to 10 million Americans suffer from chronic depression, bipolar disorder, or another serious mental illness. Depression alone is the leading cause of disability worldwide. In the United States, mental illness, including depression, takes an enormous toll on health outcomes, quality of life, and economic productivity. In 2014, an estimated 44.7% of the 43.6 million adults with any mental illness, and 68.5% of the 9.8 million adults with serious mental illness received mental health services in the past year. (Frohlich and Stebbins 2016)

The road to wholeness and acceptance presents many challenges for the black family and the community; and for the person trying to navigate their way. According to Jean Neely, “Many Christians are not encouraged to seek counseling, but instead are encouraged to pray harder and have more faith” (Neely 2018). Living in constant fear of rejection is painful. If there is a thin line between sane and insane, where does the happy medium exist where the disease does not control every part of a person? When does it become acceptable to share with others the stigmatism associated with living in bondage and living with a disease that can be debilitating; and not be ostracized or judged? We are a people that work hard to overcome the stigma associated with slavery, and it was painful and humiliating. James Cone argues, “The task of theology is to show the significance of the oppressed struggle against inhuman powers, relating the person’s struggle to God’s intention to set the person free” (Cone 1997, 90-91). As a race of people, we have worked hard to bring ourselves out of bondage to some semblance of stability. Mental illness has become the new oppressor to a race of people and community who really does not accept the disease. To be confronted with an illness that completely changes how people view you and how you view the world; it is painful, debilitating and life changing. This disease says to the average person that something is wrong with you and the life that you are attempting to live; that is resulting in a life of confusion and isolation, will never be joyful again and each day becomes a day of just existing in misery.

Moreover, Cone argues, “Because we know that we can trust the promise of God, we also know that the oppressed will be fully liberated” (Cone 1997, 91). From the historical viewpoint, the scripture lesson about the Gerasene demoniac and his tomb of imprisonment is about what was culturally acceptable at the time. The support system of the mentally challenged requires Jesus to intervene. In order for the mentally challenged to be reintegrated into being a part of the African American faith community, Jesus requires the church to intervene and together find a way out of this tomb of ‘death of isolation’. If you were found to be demon possessed, it was acceptable to live apart from community because you were different. Historically, for mental health issues, people are not different in their need to survive and culturally they are not different in what is believed. What becomes challenging is our ability to recover from the mental health stigma for both the ill person and the surrounding community. As Terrie Williams says in *Black Pain*, “There are five things good Christians say that they should not say: you need to be delivered, we can pray it away, we gotta get the devil out of you, God can heal you from anything or the church is all you need” (Williams 2009, 214). For the African American race, when the difference is more cultural than historical, there is more denial than acceptance of medical advances. As a race, we must dig deep into ourselves and our belief system to see other options. Medical advances, along with counseling are ways to ease a person’s struggle, while allowing the church and the community to see the change in the person. That same progression allows the community to be a part of the change process by being more supportive, non-judgmental and meeting people where they are.

Let's Start the Conversation on Mental Health

Just the stress of everyday living and survival is enough to negatively impact anyone's mental balance. When there are trials coming from multiple sources, all converging at one time or continuously at multiple times and in multiple ways, your mental balance stays in over load. There are many reasons, several concerns and numerous things that each of us must deal with in just living life. Juggling all of the things that life hands us, without a solid support system will result in a person withdrawing from the problem and society. When does the black church, the AME church in particular, join the conversation? Hays tells us in *Black Churches' Capacity to Respond to the Mental Health Needs of African Americans that,* "Because of the historic and current socioeconomic conditions many church members experience. Black churches have had to go above and beyond what might be expected from a religious institution to meet the holistic needs of their community" (Hays 2015, 296-312).

When faced with so many challenges, such as poverty and homelessness, that pulls the church in so many directions, it becomes difficult to identify that which is required for daily living from a 'wish list of good to have.' According to Hays, mental wellness support will make us better as a race.

> Without question the Black church has and continues to be one of the most important institutions in the African American community. Black churches have been central in helping African Americans overcome slavery, segregation, discrimination, economic depravity, educational inequities, and other social injustices. Black churches have taken on the role of social service provider when government programs failed to meet the needs of African Americans. Although it can be argued that African Americans have better access to formal services now than ever before, the Black Church is still a preferred source of help for many individuals because it is trusted in the community. Thus, any conversation about

> reducing health disparities faced by African Americans is incomplete without considering the role of Black churches. (Hays 2015, 296-312)

Maybe the AME church needs to join the conversation that has already begun in other denominations with an intentional focus on mental health. Hays says that, “Racial disparities in mental health care faced by African Americans are both a social justice problem and a public health concern because untreated mental illness is associated with individual and societal burdens” (Hays 2015, 296-312). There are plenty of social issues where the church can provide resources, but with something so devastating and life changing as mental health that impacts the family and community, the church should not only join the conversation, but also expand resources. But, the community has to consider the ability of church members, including the leaders, to move the effort forward. Hays tells us, “There is limited evidence regarding the effectiveness of church-based interventions and the capacity of Black churches to tackle mental health issues” (Hays 2015, 296-312).

Brewer and Williams, author of *We’ve Come This Far by Faith: The Role of the Black Church in Public Health*, believes “An important priority for the Black church is to become more proactive in addressing the mental health and substance abuse crisis that are adversely affecting the African American community” (Brewer and Williams 2019, 385-386). The AME church, the black church in general, and the black community celebrate the song and the lyrics of “We Come this Far by Faith.” Because we are leaning on the Lord, and we are trusting in his holy word, because we believe with all of our being, God has never failed the black community yet; our faith is strengthen. Mental health is not just

appearing on the churches' radar. So have we failed our church members and our community? In scenarios where the church does not know the answer or does not know what to do next, we pray and wait for Jesus to guide us. Brewer and Williams stated the following:

> Unfortunately, there is often a view that mental illness is a failure of one's religious faith or a mark of shame. Overcoming the stigmatization of mental illness is imperative, as stigma can lead to a reluctance to seek needed therapy. The Black church could use its influence to transform negative beliefs toward those struggling with mental illness to supportive attitudes and initiatives that promote psychological well-being as a part of spiritual well-being. Mental health could easily be integrated into church-based health interventions focused on health issues such as hypertension, diabetes and obesity. (Brewer and Williams 2019, 385-386)

Is the Black Church Mentally Challenged?

The strength of the black church is grounded in the word of God. The cohesiveness of the black church is found in the zealousness of her desire to provide for those who need assistance; except in the case of those who need mental health support. Yet, Floyd-Thomas tells us, "Where society created social division for Black people, the Black Church formed a base of solidarity" (Floyd-Thomas 2007, 124). In some cases, when it comes to mental health, we avoid the conversation on how to start engaging mental health disorders through the lens of God. But Brewer and Williams believes that, "The Black church is well positioned to accomplish this feat. Previous research reveals that in times of emotional distress, African Americans, like others, are more likely to turn to clergy than to formal mental health services" (Brewer and Williams 2019, 385-386).

Somehow within the church and the churches' efforts in mapping out the engagement process for the black community, mental health concerns were excluded from their base of solidarity. The church suffers from avoidance and personality disorders. The church's pattern of thinking and behavior significantly differs from the expectations of society and are so rigid that they interfere with the church's normal functioning. Brewer and Williams claim that, "Faithful families, grounded in the socioecological model for behavior change, 'meets congregations where they are' by equipping churches with support and resources for program implementation" (Brewer and Williams 2019, 385-386). Now that a diagnosis has been determined, if we want to be in engaged in the conversation of change around mental wellness, we have to expand our reach by getting assistance with all of our issues and concerns.

Is the black church in need of mental health support? The black church is where one goes to affirm their 'purpose' and 'identity'. You can count on those within the church to lift you up and not cast you aside because you are different. In the black tradition, the church mothers and fathers would come together to develop 'the best in you' regardless of your circumstances. For the black community, the church is the heartbeat of acceptance. When the church is no longer the welcoming body, when the church community struggles in knowing how to interact with people because of differences we do not understand, the church becomes a place of fear for all people. Avent, Cashwell, and Brown-Jeffy, in *African American Pastors on Mental Health, Coping, and Help Seeking,* make a very good point concerning church leadership. It is argued that "Within the

Black church, there remains much that is unknown about pastoral motivations, beliefs, and attitudes about mental health. According to this study's findings, African American pastors often are the first line of support for parishioners' mental health and in recognizing adaptive and maladaptive forms of coping" (Avent, Cashwell and Brown-Jeffy 2015, 32-47). Looking within ourselves may aid us in seeing the needs of others.

Today, the AME churches in the Cleveland District has shown some evidence that they have joined the conversation. The church is working toward creating an inviting atmosphere for all. The community of the Geresane demoniac loved him so much they created a separate home, a prison, where he could coexist with like-minded people of God. Social development and community acceptance cease to exist in a meaningful way when the helping hand to wellness is a 'prison of isolation' that is reminiscent of 'separate but equal'. What do we do next? We need to prepare and ask ourselves have we come to a point in time, as the black race, where the motivation to make a change from this status quo of 'tolerance by exclusion' is driven by an irrational fear of the unknown? Brewer and Williams state that, "Many faith leaders are ill equipped to engage with those individuals with mental health concerns because of a lack of formal training, limited mental health resources or theological biases" (Brewer and Williams 2019, 385-386).

Why does the AME church seemly find it acceptable to co-exist with the disease knowing the devastating consequences of this 'no action policy' found in our churches? Bilkins and Allen states in *Black Church Leaders' Attitudes about*

Mental Health Services: Role of Racial Discrimination that “Mental health care providers and Black churches should develop more collaborative partnerships and cross training programs to better meet the needs of the community” (Bilkins and Allen 2015, 184-197). As we fast forward in the year 2020 and the next General Conference in July, we find that the AME church does not appear fully focused as during the time of the Free African Society on the needs of the sick because ‘other’ needs of the church have become greater. The small percentage of people who deal with mental health issues most often are overlooked by the church or do not attend church. The AMEC church has not mobilized and tackled the disease of mental illness. Brewer and Williams highlighted the following that adds to the conversations on where we are as a black church and community. Brewer and Williams contend that “More efforts are needed such as a recent initiative by the Hogg Foundation in Texas that is providing training and technical assistance to clergy and members of African American churches to reduce mental illness stigma and create a welcoming climate to advance mental health wellness and recovery” (Brewer and Williams 2019, 385-386)

Mental Health Movement in the Church

Robinson et.al, says in *Black Male Mental Health and the Black Church: Advancing a Collaborative Partnership and Research Agenda* that, “Black male mental health in the black church must move beyond health education and health promotion events. Forthright dialogues that confront societal male-specific stressors like racism and masculinity must be openly and continuously

addressed “(Robinson et .al 2018, 1095-1107). Seeking help for mental wellness is still not on the churches agenda or on the mind of most church members, even though the first stop for those who need assistance and are seeking help is at the church.

Hardy says in *Which Way Did they Go? Uncovering the Preferred Source of Help-Seeking Among African-American Christian that*, “At its core, the role of pastor is as a spiritual shepherd who tends to the personal needs of the congregants. They carry out these responsibilities through weekly worship services, bible study, and increasingly through the provision of pastoral counseling” (Hardy 2014, 3-15). There has to be a valid spiritual reason that we do not seek professional mental health. We put a lot of trust in and do a lot of things because the service is free. Even when we have health insurance in place, we seek out the church and the pastor for counseling; not because we know that the pastor is helpful, but because it is free. When do we realize that free is not what we need, but something we settle. Free allows us to stay where we are and not seek the help we need to break free from bondage.

In dealing with life and all the trials and blessings that life brings, normal takes on different meanings depending upon the environment, the attitude, the actions and the circumstance in which we find ourselves. Hardy says, “The willingness of African American Christians to discuss serious personal and mental health issues with non-religious mental health providers suggests a possible trend toward the complementary use of religious help” (Hardy 2014, 3-15). Living life with everyday factors that threaten one’s safety and well-being

lends itself to a negative impact on one's social development. When someone does something you cannot explain and you do not understand, they may be labeled as having a mental disorder which then opens the door to extreme actions, such as exorcisms and isolation.

Neely-Fairbanks, in *Mental Illness, Knowledge, Stigma, Help-Seeking Behaviors, Spirituality and the African American Church* also confirms that, "Faith-based empowerment that lies in the foundational spirituality of black culture is a vital part of the black community" (Neely-Fairbanks 2018, 162-174). The exorcism, in Mark 5:1-20, is the effort to address a problem identified by the community to get rid of demons. Today, digging deeper into the cause of 'different behavior' is required. Society, in both time periods has somehow failed the man in establishing a pathway to acceptance within the community. Is it possible that acting normal, as one sees it, and excluding professional help, should be addressed sooner than later. Hardy provides us with the following insight, "Younger congregants are growing up in an era where the black church, while still important, can be seen as a sanctuary in a purely spiritual sense. Their access to other institutions and professionals may have made help-seeking outside of the church as normative for them as help-seeking within the church was for their forebears" (Hardy 2014, 3-15). The movement within the church to support mental health is taking a different approach to providing aid; maybe it is not in the church.

The black church is still the center of gathering for the black community. Robinson lets us know that "Because of its status as pillars of black communities,

churches are uniquely positioned to provide information, services, and interventions related to mental health to individuals who are otherwise not reached by mental health focused resources" (Robinson 2018, 1095-1107). The AME church is one of those churches who should be more engaged. But this type of engagement requires the church and pastor to change the rules of engagement. Robinson goes on to say, "As such, the black church is in a strategic position to attract Black men and younger members and to be useful in ameliorating a plethora of social problems and conditions that plague the African American community. Some of these social problems include but are not limited to drug addiction, single fatherhood, unemployment, poor self-esteem issues as a result of negative stereotyping and marginalization and police brutality" (Robinson 2018, 1095-1107) .

How Do We Change

We look forward to the day when acceptance is real within the church. Leslie James writes in *The Africana Bible: Reading Israel's Scriptures from Africa and the African Diaspora* that,

> Feelings of exile, slavery, disjunction, loss, alienation, social death, resistance, remembrance, and return accompanied the forced dispersion of Africans from their native homeland. Since these are also major themes in the Bible, subaltern Africans in the Americas or in Africa could read and identify with the biblical texts, especially the Hebrew bible narratives. (James 2010, 12)

The desire for freedom plus a better life was ever present. My project focuses on the 'presence of the church' and the leadership role of the church for those who suffer with mental health issues. Within the black community, mental illness is not

a change that is embraced, but becomes a time of rejection and repudiation because the person's value as a contributor to the larger community is greatly diminished.

Mental illness, in the church carries a stigma with a religious component. The God we serve does not make a mistake and surely someone that is different is not a mistake. The God we serve can do all things, even when it comes to restoring a mental imbalance or a mental break. The God we serve welcomes all people, even the ones with a mental health concern. Professor Norissa Williams is a clinical assistant professor that works in NYU Steinhardt's Department of Applied Psychology and she contends that in the black church, "There is sometimes this notion or beliefs that if you have a problem, take it to God in prayer. If you have a problem, God will solve it and if you seek other outside help, it's because you're weak and not trusting God" (Williams, 2018).

Mental health concerns touch all races and all families in some way or the other because they are multiple and varied. Some black preachers have ceased to take on the role as a change agent because the complexity of the problem is greater than the educational and practical knowledge of most pastors. Jackson contends that "Historically Black preachers have served as interpreters not only of Christian scripture, but also of the Black experience in society and the overall life experience in the Black community" (Jackson 2013, 30). The preacher uses the word of God as the way out of bondage and the word of God becomes the living hope. Encountering the word of God and those who believe in the word of God leads to acceptance for the mentally ill. The word of God contains that

sustaining momentum that gives us strength; no matter the struggle, to work toward a God driven purpose. The road to wellness for a person suffering with mental health challenges, within the church, is very hard to find and/or follow. But in living life we find that God will sustain us as we seek medical help.

In the article, *The African American Minister as a Source of Help for Serious Personal Crises: Bridge or Barrier to Mental Health Care?* Musick, Neighbors and Williams argue,

> Although there is a fair amount of research published on the socially supportive role of Black churches, surprisingly little has been written about the precise functions of Black minsters in counseling African Americans with mental health problems. Much of the literature on the mental health role of Black ministers remains more speculation and conjecture than empirical documentation. (Musick, Neighbors and Williams, 1999)

In order for churches to make a difference, we must start to always see the person as an individual seeking acceptance in an environment where fear is often the leader in determining the treatment. The church or the pastor is still traveling the journey to learn the where, what, how, and when of a mental health disorder. The church should make an efforts to embrace and keep the mentally challenged as an active part of the body of believers.

When the church is standing in the gap, life is better. Williams contends that, “Many mental health advocates say that because black faith leaders are held in such high esteem, their efforts to raise awareness and encourage members to seek help can be life-changing. Religious institutions can reduce the stigma of mental illness by offering programs and being open to ideas to help their members.” (Williams, 2018). Who can stand and respond to the needs of the black community? The black church, even though it is still learning, is where

we start. The church has always been present through the struggles of civil rights to acceptance of those who suffer with a mental disorder.

The plight of the mentally challenged in the black community and black church has gotten lost in the lack of statistics. For the black church we do not keep accurate records of the various mental health issues that the church and community must deal with. We do a much better job in keeping track of who pays tithes and offering than we do on how many people are not in church service due to depression, suicidal thoughts, and other issues. According to Lund, “Families and communities of faith need to be intentional and proactive about changing this culture of shame, secrecy, and stigma. Testimonies only work when there is a place to testify, a safe place to tell the truth. And healing happens when testimonies are given and received within community” (Lund 2014, 96). But we are there and we are looking for help and a place to feel safe. For the Gerasene demoniac, it was not a story surrounding how many people had been ostracized and made to live in their man-made home, but a story about non-acceptance within their own community. Winlock argues, “Freezing and being cut off from what you want in life is like hiding in the forest and reacting to things that are bigger and you cannot change” (Winlock 2013, 305).

In *Undoing Crazy*, Colette Winlock’s story takes us into the life she lived in her mind. It takes us through the avoidance when all of the “pot liquor or hope is gone” (Winlock 2013, x). When you stop living and stop moving, that which brings life to you is gone and the mind becomes the new prison where you have to undo all the crazy; undo the road blocks and obstacles that hold you back. In

Mark, the man that was possessed by demons was placed in the prison because it was believed that was a better solution than being in his own home. The demon possessed man was part of the community with the community of oppression being a subset; just as the mentally challenged are part of the church community, but unfortunately have not received full acceptance within their church.

Immersed in the word of God, waiting for this God of justice and still searching for this promised future brings us to our present reality in 2020 and still no help for the mentally challenged. Getting help for a mental health condition in my culture's eyes is a sign of weakness, a personal flaw—not a legitimate, clinical condition. According to Bryant, "Sixty-three percent of African-Americans believe that a mental health condition is a personal sign of weakness" (Bryant 2018). God and the Bible, our history and slavery, our values and cultures, make up the life experience of the African American race which still holds the key to our biblical understanding; but we have not found a direct focus on mental health issues. We are still dependent on individual efforts utilizing a professional referral system. The community and the church now depend on the pastor and resources from other sources outside of the church. The church has not taken up the mantel for assistance.

Where is the church and where is God as the persons with mental health conditions continue to struggle and pull away from the church? In *Blessed are the Crazy*, Sarah Lund, argues that "crazy [is] in the blood" (Lund 2014, 106). Mental illness flows throughout our veins. It is part of living life so the disease

cannot be taken away. Again, from listening to my brother's stories and struggles that he now uses to describe this life, I wonder how we missed it. I wondered where did it start, and why did we, his family, just miss or dismiss it. My brother now uses the movie, *A Beautiful Mind*, to describe his journey with mental illness from childhood to his first mental break. The movie provides some insight in how he was able to hide his mental state.

Mental Health concerns will touch families in the black church in some way. The black church and community must stand in the gap for the sick, which includes those who suffer from mental health challenges. Lund lets us know the following:

> Mental illness cannot be wished or prayed away. The stigma and shame about mental illness only increases its destructive power. Hiding in our closets, in our homes, we are swallowed up in its shadows. It is my confession that by exposing mental illness to the healing light of God, through testimony, through carrying one another's burdens, through therapeutic circles of care, we can find hope and strength. It is my hope that the church can be a community of truth tellers, decreasing stigma as we create safe, welcoming spaces for people with mental illness. It is my testimony that the God of love is with us, even when there is crazy in the blood. It is my gospel truth that blessed, not cursed, is the crazy for we all are children of God. (Lund 2014, 1)

CHAPTER FOUR

DESIGN, PROCEDURE, AND ASSESSMENT

The purpose of this chapter is to outline the steps that aided in developing the design, procedures and assessment of this project. The focus of my project was to discover the knowledge, attitudes and actions of parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME). In addition, the context, participants, procedures, assessments, project overview and goals will be reviewed and analyzed in this chapter.

The subject of mental illness was so broad with many published opinions, thus, the scope of the project was narrowed to the following: evaluation of the secondary literature on the subject matter; discovering the knowledge, attitudes, and actions of the parishioners about the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME); and the evaluation of the study.

Context

The context of my project was the Cleveland District of the African Methodist Episcopal Church (AMEC), a church organized out of desire for religious freedom. Dennis C. Dickerson, Retired General Officer of the AMEC says,

> The African Methodist Episcopal Church (AMEC) was organized in 1794 in Philadelphia, PA, with Bethel AMEC as the first church where Richard Allen served as Pastor and was ordained as the first Bishop. The word African means that people of African descent and heritage organized the church. The AMEC grew out of the Free African Society which was a mutual aid society organized by Richard Allen, Absalom Jones, and others established in Philadelphia in 1787. When officials at St. George's Methodist Episcopal Church pulled blacks off their knees while praying, Free African Society members discovered just how far American Methodists would go to enforce racial discrimination against African Americans. Today, the African Methodist Episcopal Church has membership in twenty Episcopal Districts in thirty-nine countries on five continents. The work of the Church is administered by twenty-one active bishops, and nine General Officers who manage the departments of the Church. (Dickerson 2017)

The North Ohio Conference of the AMEC is in the Third Episcopal District which is comprised of Ohio, West Virginia, and the Western half of Pennsylvania. The North Ohio Conference is in the northern half of Ohio and is comprised of two conferences: the Youngstown District and the Cleveland District. The Cleveland District is headed by a Presiding Elder that oversees 16 churches that is comprised of 3,905 members. The majority of the 16 churches are in Cleveland, with churches located in Mansfield, Toledo, Lima, Elyria, Lorain, Crestline, and Sandusky, Ohio. Dickerson goes on to say that,

> In the post-civil rights era theologians James H. Cone, Cecil W. Cone, and Jacqueline Grant, who came out of the AME tradition critiqued Euro-centric Christianity and African American churches for their shortcomings in fully impacting the plight of those oppressed by racism, sexism, and economic disadvantage. At every level of the Connection and in every local church, the AME Church shall engage in carrying out the spirit of the original Free African Society, out of which the AME Church evolved, that is to seek out and save the lost, and to serve the needy and stay true to the ultimate purposes, which is to make available God's biblical principles, spread Christ's liberating gospel, and provide continuing programs which will enhance the entire social development of all people. (Dickerson 2017)

Even though the AMEC was birthed out of adversity and has a mission to minister to the social, spiritual, and physical development of all people, as a church we still fall short in educating and supporting members with mental health challenges.

What is it about the AME church and the AME church family that prevents open conversation about mental illness? I am a cradle AME, meaning being born into the AME church. The majority of my family are still members of the AME church or prior members of the AME church and I have pastored for over twelve years in the AME church. My AME connectional family, continues to expand; yet, embracing difficult subjects such as mental wellness has not been dealt with. In my years in the church as a member, youth pastor, associate pastor and pastor since 2008, I have seen many members with mental health challenges resulting in suicide, suicide attempts, broken families and indescribable hurt, but have not been a witness to ministries for mental health.

Participants

The project participants were all members of the AME churches located in the Cleveland District of the North Ohio Annual Conference. Participants were male and female. Participants included clergy and lay members of the church who were pastors, associate pastors, lay leaders and officers within the church. Most participants completed the survey during a gathering of the Cleveland District. The survey was taken manually at the following meetings: the Cleveland District Conference held on April 21, 2018, which is mandatory for the Pastors

and at least one Steward from the sixteen churches; there were fifty-two (52) individuals in attendance. The Cleveland District Church School Convention that was held on June 9, 2018, is mandatory for Pastors and church school teachers; there were approximately forty-two (42) adults in attendance. The Cleveland District Planning Meeting that was held on November 17, 2018, is mandatory for the sixteen Pastors and at least one Steward; there were fifty-six (56) attendees. Surveys were distributed to everyone in attendance at all meetings and ultimately 33 surveys were returned. The survey was emailed to all Pastors, Ministers and Lay leaders; but only two surveys were returned via email and one survey via the U.S. Postal Service.

All project participants volunteered to take the survey and only thirty-three (33) participants returned a completed survey out of seventy-six (76). The project requested identification of male or female with no other identifiers, but all participants were over the age of eighteen years of age and Black. There were no incentives offered to survey participants. The survey partakers were told that it was voluntary and confidential so please do not sign or write their name. They were also informed that the field supervisor would develop the data base and complete the analysis. At least six survey participants had stories of their own concerning mental illness and wanted to add more questions to the survey concerning educational information.

Procedure and Assessment

The purpose of my project was to discover the knowledge, attitudes and actions of parishioners about ministering to the mentally ill in the Cleveland District. Ensuring that sufficient information was obtained required extensive reading and research on mental health in general and specifically within the AME church. The following steps were taken to obtain information for the project:

- Collected and read primary and secondary material on various forms of mental illness, mental health awareness and mental wellness.
- Collected and read information on definitions of mental illness.
- Collected and read information on resources within the church and local communities that were available to help persons diagnosed with a mental health issue and aid for the family and care giver.
- Searched for information on mental health support groups and/or ministries in AME churches in the Cleveland District, in the North Ohio Conference, in the Third Episcopal District and the Connectional Church.
- Held conversations with those who appeared to have extensive information on the subject of mental illness.
- Held conversations with family members on the subject of mental illness and mental health.
- Searched the internet for articles on mental illness within the AME church and within the Black church.
- Searched the internet for books on mental wellness by AME pastors or AME lay persons.

- Searched the internet for Black authors on mental illness, mental health and mental awareness.

The design process included establishing procedures and shaping the assessment tool, which started when the purpose of this project was finalized. The process included reviewing websites that identified resources and obtaining articles from magazines and online resources to aid in understanding mental illness. In order to capture information, the following was done:

- Created a survey for distribution to discover the knowledge, attitudes and actions of parishioners about ministering to the mentally ill in the Cleveland District.
- Created three testing environments for the survey with Greater Mitchell Chapel AME church members, employees on my secular job and workshop participants.
- Leading discussions during workshops in addition to answering questions as to why particular questions were asked and why the subject of mental wellness was chosen.

In developing the survey, an evaluation of various examination methods was done based on a review of different quantitative assessment tools utilizing a scale that aids you in knowing the level of agreement or disagreement. For example, the Likert scale is used when one is asking for the degree of agreement and the Extent scales when you are measuring the extent of a skill, feeling, attitude, motivation or opinion. The project survey used a 5-point Likert scale questionnaire utilizing strongly agree, agree, not sure, disagree and

strongly disagree. Section One was designed to capture the demographics of male or female. Section Two was divided into three sections: Knowledge: sixteen questions were used to capture the knowledge of the participants. By utilizing various definitions of forms of mental health diagnosis that are common, not so common, and those that would normally not be connected to a mental illness, such as hoarding, the survey captured the following: Knowledge: sixteen questions were used to capture what is known about the various mental health disorders. Attitudes: sixteen questions were used to capture the beliefs that aid in forming attitudes concerning those with mental health disorders. Action: sixteen questions were used to see if the person taking the survey was willing to participate in support ministries that would allow interactions with persons diagnosed with mental health conditions. Section Three was used to evaluate the study and five questions were used to capture the impact and effect on the person taking the survey. See Appendix A for the Survey Tool.

Analyze and Evaluate Material

Evaluation and analysis was framed by the efforts to learn more about their knowledge surrounding mental illness and its impact on creating attitudes and measuring actions. Survey participants brought with them preconceived ideas about the disease; but more dangerous than lack of knowledge was “real” fear that was not fully vetted. In explaining this project, it was found that some people really wanted to take the survey and help; and some individuals conveniently shied away. After opening up to an individual or group about family

struggles with my brother, why this particular subject matter was selected, and why the topic was my family struggle, enthusiasm increased greatly. The real-life story made people remember when my brother had his first mental break and how the diagnosis changed as his life was rearranging. Some people wanted to tell their story, the story of their family, the acceptance or non-acceptance of family and how the journey changed their life. I have done three presentations in the Cleveland District in the AME church after the survey process was completed.

Collecting written information and stories on mental health and difficulties related to this project within the AME church was challenging. As I came across articles, I would copy and/or scan them for my research. I collected primary and secondary material on various forms of mental illness, mental health, mental wellness and the journey to wholeness. After email distribution of the survey, it was discovered that emailing the survey was not the method that would net the best results of a completed survey; as only two surveys were received via email. The distribution and collection of the questionnaires in a face-to-face setting was far better than the use of an online survey application.

Analysis of the survey was based on the frequency of answers to the survey questions by the project participants. Analysis of the project also looked at the number of times questions were not answered, conversations from lived experiences, testimonies from others and books that were read. The questions in the survey were grouped in categories to allow the respondent to be consistent within a pattern.

In reviewing the various literatures, listening to mass media, evaluating local, state and federal resources, one can acknowledge that the church is trying to join the conversation on mental health disorders, but one would have to wonder what would really happened if the church showed up in a committed way? Today, if the church joined the conversation it would need to catch up on what is a mental health disorder, who are trained as mental health advocates, what are the health professionals asking people to do to educate themselves, where does the church play a role in changing how others view mental health disorders, and how to aid churches in becoming activists and leaders in the Black community on mental health. For the church to stay at “arm’s length” says the church continues to live in denial of a disease that impacts the life of so many people in and connected to the church.

Summary

The design, procedures and assessment of my project was guided by an ongoing quest to discover the knowledge, attitudes and actions of the parishioners about ministering to the mentally ill in the Cleveland District of the AME church. Even before the survey results were known, attitudes about mental health conditions were being shared. It was disappointing that the AME churches in the Cleveland Districts do not play a more active role in mental health ministries. In documenting the mental health services that are out there and the entities that play a role in offering referral services or even hosting a mental health event, the Cleveland District AME church members were still missing.

When AME members started to disclose their struggles, it was unfortunate that mental health diagnosis for the person or family member placed individuals in situations that forced them to hide or down play the illness.

A mental health diagnosis places not only the sick person, but the family members and friends in a secret society that promotes secrets instead of public conversation on how to offer aid. Even when someone was being supportive it was always in reference to someone else and never about the struggle that Jesus has seen them through. I began to think that we believe that the illness should not touch us or our family and that it is a disease caused due to physical or mental abuse, homelessness and excessive drug use. Many conversations were heard that did not support the church having a role with mental health. Even though we believe that there is nothing too hard for God, we do not believe it in all circumstances.

Achievement of my personal goals to obtain a better understanding of the various ways people deal with mental illness was met. To have a greater concern that turns into action for people who are sick or ostracized because of a mental health concern was partially met. Furthermore, to work harder to preserve my own health so I can be a better pastor was partially met. Changing a culture of non-acceptance for the mentally challenged to acceptance when it goes against the norm of the black church and black community is not a small task and requires a committed and educated team.

Society molds our expectations and in the black church the mentally challenged are not fully embraced and therefore must remain in their place where

one is accepted. Society's expectations do not allow or tolerate non-compliance of "place" for any extended period of time. If one moves into the unacceptable realms of expectation, we no longer allow ourselves to see the person and the needs of the person. Instead, we see non-compliance that turns into fear and isolation. We are all born in the image of God, yet we live on the edge of acceptance and non–acceptance. To be weighed down with mental illness and then to have access to resources to function within the illness is like standing at the border of what is socially acceptable trying to understand why one cannot cross over.

Evaluation of results of the survey will be reported in Chapter Five. The appendix of all books and sources is located after Appendix Two – Assessment Tool, titled "Reference."

CHAPTER FIVE

REPORTING THE RESULTS

The focus of my project is to discover the knowledge, attitudes and actions of parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME). In 2012 my family started a mental health journey with my brother who was diagnosed with depression, then bi-polar disorder and presently paranoid schizophrenia. When I started this project, I only wanted to help my brother get his life back. I was not trying to diagnosis his illness; just get him back to normal. Through this project, I now know that I was grossly under prepared with insufficient knowledge on mental wellness, a flawed belief system concerning the disease and a mission that was bound to fail.

At the start of this DMIN project, I had not concluded that there is "crazy" all around; especially in the church. I knew hoarding, I knew social isolation, I knew hyperactivity, I knew continuous anxiety, I knew alcoholism, I knew depression, I knew drug addiction, I knew sexual addiction, I knew overeating, I knew obsessive compulsive disorder, I knew bi-polar disorder and I knew paranoid schizophrenia. Never did I think that mental illness was so close and prevalent in the church; until I took a journey through multiple mental health challenges. What I did not know was there is a real struggle of not being accepted because of a mental health condition. To be surrounded by others who are fearful of you and now

imprisoned by that same fear within yourself; which now defines your quality of life and the family's quality of life, is real. I now understand why people, who have sought successful treatment, or all too often live in silence.

Goal #1: To Evaluate the Secondary Literature

The purpose of this goal was to ensure that what is cited on the subject of mental illness is not only relevant, but that the literature provides valuable information on how the black church and black community have dealt with and is dealing with ministering to those with mental illness. To evaluate the secondary literature on the subject matter allows a look back to the history of the black race, the black church and the impact of oppression. The literature allows an evaluation and acceptance of the present state of the relevancy of the black church in ministering to those with mental health issues. It also takes a look forward to the future in how the church could change in developing and supporting ministries to aid those that are dealing with mental illness.

The church has been the place for the black community where ministries have been birthed. Through secondary literature that highlights the real life impact of mental health challenges and the corresponding effect on the church, family members and those that were connected to the person, this project was able to review what others encountered as they journeyed with a loved one or when they took the journey for themselves, with a goal to reach a place of normalcy. Concerning the effects and impact of mental illness, greater

knowledge and understanding on how diverse mental health challenges are that impact our lives was gained due to the insight revealed by the various authors.

In the past, the word ‘crazy’ was used to describe what we thought was different or abnormal behavior. Today, we get to know mental health challenges from clinical definitions found through real life challenges of various types of crazy or “odd type ailments” where we have no clue as to what it is. It is fortunate, yet very challenging, and very telling, that the black church and its ministries has not caught up with the continuous evolution of the disease. Stories that were once associated with the many side effects of mental illness are now everyday occurrences. Due to this continuous influx of knowledge through ongoing dialogue and through books on the subject, I gain greater insight on how to aid others and ourselves. In the books, *Blessed are the Crazy* by Sarah Griffith Lund (2014), *Christ On The Psych Ward* by David Finnegan-Hosey (2018), *Undoing Crazy* by Colette Winlock (2013)*, Black Pain – It Just Looks Like We’re Not Hurting* by Terrie M. Williams (2009), and *72 Hour Hold* by Bebe Moore Campbell (2006), we get to see the effects of medical treatments, lack of the proper medical treatment, development of support systems, and the direction of the church.

Moreover, I used secondary literature to engage God as the strength in the church. The secondary literature provided insight into God and how God influences the quality of life of the mentally ill. God’s guidance to a committed church and God’s presence in the struggle of the life of the mentally ill person within the church is what brings about real change. Did God intend for the mind

to create an unbalance life that leads to fear, isolation and being ostracized within the church? Books such as, *DSM-5 Made Easy – The Clinician's Guide to Diagnosis* by James Morrison (2014), *Insanity of Theology* by Dr. G. Martin Young (2014), *Forged in the Fiery Furnace* by Diana L. Hayes (2012)*, Theology Brewed In An African Pot* by Agbonkhianmeghe Orobator (2008), *Canaan Land: A Religious History of African Americans by* Albert J Raboteau (1999), *Virtues and Values: The African and African American Experience* by Peter J. Paris (2004), *Blackening of the Bible: The Aims of African Biblical Scholarship* by Michael J. Brown (2004) and *Black Church Studies: An Introduction* by Stacey Floyd-Thomas et.al (2007), speaks to us about God's presence in the life of the person and the church. God is always present with us and guides our faith, belief and thoughts.

Next, secondary literature was key in understanding the impact of life challenges such as slavery, racism, poverty and placism and how those challenges impacted the mental health diagnosis and disrupted the journey of recovery. Using secondary literature to gain a greater understanding through the eyes of the oppressed is seen in sources such as: *Black Rage* by William H. Grier and Price M. Cobbs (1992), *Unfinished Business Black Women, the Black Church and the Struggle to Thrive in America* by Keri Day (2012), *The Souls of Black Folk* by W.E.B. Dubois (1903), *The Black Church in the Post-Civil Rights Era* by Anthony B. Pinn (2002), *God of the Oppressed* by James H. Cone (1997)*, The Social Teaching of the Black Churches* by Peter J. Paris (1985), *For the Souls of Black Folks – Reimagining Black Preaching for 21st Century by* Cari

Jackson (2013), *A Black Theology of Liberation by James H. Cone* (1986) and *Exiled in my own Home: An African-South African Perspective on the Bible in the Africana Bible* by Madipoane Masenya (2010).

Online research sources on the black church and mental health issues was used to gain information and views from others on mental illness within the black community with a focus on how the individual and the community has been impacted. Research papers and articles such as *We've Come This Far by Faith: The Role of the Black Church in Public Health* by LaPrincess C. Brewer and David R. Williams (2019), *Mental Illness, Knowledge, Stigma, Help-Seeking Behaviors, Spirituality and the African American Church* by Shameka Y. Neely-Fairbanks (2018), *Which Way Did They Go? Uncovering the Preferred Source of Help-Seeking Among African-American Christians* by Kimberly Hardy (2014), *Black Male Mental Health and the Black Church: Advancing a Collaborative Partnership and Research Agenda* by Michael A. Robinson, Sharon Jones-Eversley, Sharon E. Moore, Joseph Ravenell and A. Christson Adedoyin (2018), *Black Church Leaders' Attitudes about Mental Health Services: Role of Racial Discrimination* by Brianna Bilkins and Angela Allen (2016), *African American Pastors on Mental Health, Coping, and Help Seeking* by Janee´ R. Avent, Craig S. Cashwell and Shelly Brown-Jeffy (2015) and *Black Churches' Capacity to Respond to the Mental Health Needs of African Americans* by Krystal Hays (2015).

Lastly, the internet was used to gather information on mental illness in the black church and was very helpful in identifying how poverty, fear, denial and

rejection impact treatment of mental illness within the black community. Resources such as articles by Thomas C. Frohlich and Samuel Stebbins on *12 States Struggling with Mental Illness* (2016), *Mental Health Definitions* by the American Psychological Association, American Academy of Child & Adolescent Psychiatry as reviewed by Joseph Goldberg, MD (2014), *How the Church's Approach to Mental Illness Can Shame the Suffering* by Jean Neely (2018), *Silent Stigma of Mental Illness in the Church* by Dr. Robyn Henderson-Espinoza (2017), *How Churches are Addressing the Mental Health Needs of the Black Community* by Dr. Laverne Williams (2018), and *The African American Minister as a Source of Help for Serious Personal Crisis: Bridge or Barrier to Mental Health* by Harold W. Neighbors, PhD, Marc A. Musick, PhD and David R. Williams, PhD (1999).

Goal #2: To Discover the Knowledge

The second goal of this project was to discover the knowledge of parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME). Section One of the survey contained the demographics for each participant. A breakdown of the participants by gender revealed the following: twenty (20) females, twelve (12) males and one (1) incomplete on demographics for a total of 33 participants. Sixty-one percent (61%) of the participants were female, thirty-six percent (36%) of the participants were male and three percent of the project participants (3%) is unknown.

Section Two of the survey consisted of three parts, each containing sixteen questions. The survey tool used a five-point Likert scale which was designed to capture the knowledge of the participants on what is considered a mental health challenge and knowledge of resources that are available within the community. Table 1 below captures the responses on knowledge:

Table 1: Knowledge (Agreement)

Questions		Average Rating	Percentage of Participants (Strongly Agree and Agree)
10	I know that clinicians have developed treatments for mental health disorders that allows the person to function in society?	4.34	94%
12	I know that mental health professionals have established services that will aid a person with a mental health crisis?	4.31	91%
14	I know that physicians categorize mental health as a vital part of overall wellness?	4.29	87%
1	I know that clinicians categorize depression as a mental health disorder?	4.24	85%
5	I know that clinicians categorize drug addiction as a mental health disorder?	4.12	76%
4	I know that clinicians categorize alcoholism as a mental health disorder?	4.09	79%
9	I know that clinicians categorize continuous anxiety as a mental health disorder?	4.07	80%
2	I know that clinicians categorize hoarding as a mental health disorder?	4.03	73%
8	I know that clinicians categorize social isolation as a mental health disorder?	3.93	63%
7	I know that clinicians categorize sexual addiction as a mental health disorder?	3.85	67%
3	I know that clinicians categorize overeating as a mental health disorder?	3.73	61%
6	I know that clinicians categorize attention deficit hyperactivity as a mental health disorder?	3.67	55%
13	I know that my church provides contact information on various health organizations that provide mental health services?	3.18	41%
15	I know that clinicians categorize mental health conditions as hereditary?	3.09	41%

Note: The scores are averages based on a total of 33 participants. They responded using a Likert scale of 1-5 (5=strongly agree; 4=agree; 3=not sure; 2=disagree; and 1=strongly disagree).

Table 1 illustrates the average and percentage of participants whose responses ranged from strongly agree (5), agree (4), not sure (3), disagree (2) and strongly disagree (1) in the knowledge section of the survey.

On question 10, “I know that clinicians have developed treatments for mental health disorders that allows the person to function in society.” The average rating was 4.34 out of a possible 5.0 and 94% of the participants strongly agree that treatment is available that allows a person to function within the community. This is the highest rating on any of the knowledge questions. This suggests participants know that mental health treatments are available.

On question 12, “I know that mental health professionals have established services that will aid a person with a mental health crisis.” The average rating was 4.31 out of a possible 5.0 and 91% of the participants agree or strongly agree that mental health professionals have established services to aid those dealing with mental health challenges. This seems to indicate that participants know mental health professionals are available to assist with mental health crisis.

On question 14, “I know that physicians categorize mental health as a vital part of overall wellness.” The average rating was 4.29 out of a possible 5.0 and 87% of the participants agree or strongly agree that physicians categorize mental health as a vital part of overall wellness. This suggests participants know that mental health is a vital part of overall wellness.

Observations gleaned from the responses to questions 10, 12 and 14, perhaps indicate that there has been an increase in the efforts to educate the

community on the necessity of seeking assistance when needed and most see the value of mental health as a vital part of overall mental wellness. Today most work places provide employee assistance programs to support mental wellness.

On question 1, “I know that clinicians categorize depression as a mental health disorder.” The average rating was 4.24 out of a possible 5.0 and 85% of the participants agree or strongly agree that depression is a mental health disorder. Participants definitely seem to acknowledge that depression is a mental health concern.

On question 5, “I know that clinicians categorize drug addiction as a mental health disorder.” The average rating was 4.12 out of a possible 5.0 and 76% of the participants agree or strongly agree, 21% of the respondents are not sure an 3% disagree or strongly disagree that clinicians categorize drug addiction as a mental health disorder. This is striking. With greater awareness of drug addiction, mass media coverage of celebrity drug use, overdose and deaths, drug addiction within the community; drug use is more common. Perhaps these participants have accepted the disease as a way of life instead of a mental illness. Drug addiction has crossed over or is crossing over to an acceptable illness.

On question 4, “I know that clinicians categorize alcoholism as a mental health disorder.” The average rating was 4.09 out of a possible 5.0 and 79% of the participants agree or strongly, 15% of the respondents are not sure and 6% disagree or strongly disagree that clinicians categorize alcoholism as a mental

health disorder. However, perhaps there is a tendency to accept the disease as a way of life instead of a mental illness. Alcohol is legal for adult consumption and has crossed over or is crossing over to an acceptable illness with a very structured support system.

On question 9, “I know that clinicians categorize continuous anxiety as a mental health disorder.” The average rating was 4.07 out of a possible 5.0 and 80% of the participants agree or strongly agree and 20% of the respondents are not sure that clinicians categorize continuous anxiety as a mental health disorder. However, there were no respondents who disagreed or strongly disagreed, and 20% of the participants were unsure. Perhaps additional education is needed on the ailment as well as the side effects.

On question 2, “I know that clinicians categorize hoarding as a mental health disorder.” The average rating was 4.03 out of a possible 5.0 and 73% of the participants agree or strongly agree, 24% of the respondents are not sure and 3% disagree or strongly disagree that clinicians categorize hoarding as a mental health disorder. There is a tendency to associate hoarding as a problem of the aged. However, that is not the case and views on attachment of and to excessive things have placed lives in danger. This requires further study.

On question 8, “I know that clinicians categorize social isolation as a mental health disorder.” The average rating was 3.93 out of a possible 5.0 and 63% of the participants agree or strongly agree, 34% of the respondents are not sure and 3% of respondents disagree or strongly disagree that clinicians categorize social isolation as a mental health disorder. The participants seem to

be less concern about the health implication of isolation than they were on earlier items. Perhaps, the respondents are not sure of what social isolation means when a person lacks interaction with others for an extended period of time. Church ministries provide support systems that encourage interaction. Perhaps more information is required.

On question 7, “I know that clinicians categorize sexual addiction as a mental health disorder.” The average rating was 3.85 out of a possible 5.0 and 67% of the participants agree or strongly agree, 21%, of the respondents are not sure and 12% of the respondents disagree and strongly disagree that clinicians categorize sexual addiction as a mental health disorder. The participants do not seem to have very strong awareness of sexual addiction as a mental health concern. However, respondents may see this as something that goes away with time, just does not know what it means or it is a spiritual matter. Perhaps, respondents are uninformed of the effects of sexual addiction or addictive behavior and do not see it as a mental health challenge.

On question 3, “I know that clinicians categorize overeating as a mental health disorder.” The average rating was 3.73 out of a possible 5.0 and 61% of the participants agree or strongly agree, 24% of the respondents are not sure and 15% disagree or strongly disagree that clinicians categorize overeating as a mental health disorder. Agreement on this item is not very high. Church ministries are built around meals. Churches and communities have support systems that provide food. In some cases, over eating is seen as a byproduct of childhood obesity because food is used as a reward. While eating for comfort,

pleasure, and stress release is acceptable behavior. All of what was listed can lead to compulsive eating that one cannot control. Perhaps this requires more detail study.

On question 6, “I know that clinicians categorize attention deficit hyperactivity as a mental health disorder.” The average rating was 3.67 out of a possible 5.0 and 55% of the participants agree or strongly agree, 36% of the respondents are not sure and 9% disagree or strongly disagree, that clinicians categorize attention deficit hyperactivity as a mental health disorder. Agreement on this item is not very high. Possibly the survey respondents are not sure of what it means to have attention deficit hyperactivity. It is acceptable for school age children but it is treatable and not curable; which means it also impacts the life of adults in a negative way. This requires further investigation.

On question 13, “I know that my church provides contact information on various health organizations that provide mental health services.” The average rating was 3.18 out of a possible 5.0 and 41% of the participants agree or strongly agree, 28% of the respondents are not sure and 31% of the respondents disagree or strongly disagree, that their church provides contact information on various health organizations that provide mental health services. There is neither clear agreement either way about the churches providing mental health information. Possibly, churches are doing a poor job of providing contact information on various health services to the members; and/or some churches are not providing any information on various health organizations that provide

mental health services. Perhaps medical support ministries should be evaluated in the churches.

On question 15, “I know that clinicians categorize mental health conditions as hereditary.” The average rating was 3.09 out of a possible 5.0 and 41% of the participants agree or strongly agree, 38% of the respondents are not sure and 21% of the respondents disagree or strongly disagree that clinicians categorize mental health conditions as hereditary. There is neither clear agreement either way that clinicians categorize mental health conditions as hereditary. Hoarding, drug addiction, alcohol addition, compulsive disorders seem to occur multi times in the same family; I am sure there are other disorders. Conceivably, respondents are not sure if mental health conditions are hereditary, acquired syndrome or hereditary predisposition. Perhaps additional evaluation is needed.

Table 2: Knowledge (Not Sure)

	Questions	Average Rating	Percentage of Participants Not Sure
16	I know that clinicians categorize persons showing signs of chronic homelessness by moving frequently are showing mental imbalance tendencies?	3.45	48%
11	I know that clinicians have concluded a shorter life expectancy for persons diagnosed with a mental health disorder?	3.25	53%

Note: The scores are averages based on a total of 33 participants. They responded using a Likert scale of 1-5 (5=strongly agree; 4=agree; 3=not sure; 2=disagree; and 1=strongly disagree).

On question 16, “I know that clinicians categorize persons showing signs of chronic homelessness by moving frequently are showing mental imbalance tendencies.” The average rating was 3.45 out of a possible 5.0 and 48% of the

participants are not sure, 10% of the respondents disagree or strongly disagree and 42% of the participants agree or strongly agree that clinicians categorize persons showing signs of chronic homelessness by moving frequently are showing mental imbalance tendencies. As a group, participants seemed to be uncertain about homelessness as a mental health issue. Moreover, this may indicate that respondents are not sure that homelessness is a mental illness. It may also indicate that the respondents believe that homelessness is a financial issue as opposed to a mental health issue. Another observation is that not enough is being done to educate the community on the causes of homelessness.

On question 11, “I know that clinicians have concluded a shorter life expectancy for persons diagnosed with a mental health disorder.” The average rating is 3.25 out of 5.0 and 53% of the respondents are not sure, 19% of the respondents disagree or strongly disagree and 28% of the participants agree or strongly agree that clinicians have concluded a shorter life expectancy for persons diagnosed with a mental health disorder. Again, participants did not seem to agree that mental health issues affect life expectancy. Thus, it may be concluded that the respondents are not aware or not sure of the medical impact on life expectancy with a chronic mental illness; perhaps some respondents thought that the mental illness killed the person. The respondents may also conclude that an illness of the mind is not a physical illness that distresses the body and the person takes care of themselves. Perhaps, the question could have been written a different way, or there is not enough being done to treat the mind

and body at the same time and maybe more education for the community on the side effects of medication is warranted.

Summary

Questions 10 (mental health disorders), 12 (mental health crisis), 14 (mental wellness), 1 (depression), 5 (drug addiction), 4 (alcoholism), 9 (continuous anxiety), and 2 (hoarding) have an average rating of 4.19 indicating that the respondents agreed or strongly agreed with the questions on knowledge. Those same questions account for 50% of the total16 questions. This group of 8 received more agreement.

The 6 of the remaining 8 survey questions 8 (social isolation), 7 (sexual addiction), 3 (overeating), 6 (attention deficit hyperactivity), 13 (contact information for mental health services) and 15 (mental health conditions are hereditary) have an average of 3.52 indicating that the respondents were not sure and disagreed or strongly disagreed. This group of 6 received ratings between agreement and not sure. These areas reflect more confusion or uncertainty. Observations taken from the data identifies a need to educate on the various mental health challenges.

Observation for Questions 13 (contact information for mental health services) and 15 (mental health conditions are hereditary) indicates that not enough educational information has been communicated on both concerns.

In all these area more education might be helpful. Therefore, it may be concluded that more needs to be done in educating the church and community

about mental illness and increase knowledge on support ministries for mental health issues.

Goal #3: Discover the Attitudes

The third goal is to discover the attitudes of the parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME).

Table 3: Attitudes (Agreement)

Questions		Average Rating	Percentage of Participants (Strongly Agree and Agree)
1	I believe that clinicians categorize depression as a mental health disorder?	4.30	91%
12	I believe that mental health professionals have established services that will aid a person with a mental health crisis?	4.23	81%
14	I believe that physicians categorize mental health as a vital part of overall wellness?	4.22	84%
10	I believe that clinicians have developed treatments for mental health disorders that allows the person to function in society?	4.19	81%
9	I believe that clinicians categorize continuous anxiety as a mental health disorder?	4.09	88%
3	I believe that clinicians categorize overeating as a mental health disorder?	3.85	70%
5	I believe that clinicians categorize drug addiction as a mental health disorder?	3.79	70%
2	I believe that clinicians categorize hoarding as a mental health disorder?	3.76	67%
7	I believe that clinicians categorize sexual addiction as a mental health disorder?	3.75	59%
6	I believe that clinicians categorize attention deficit hyperactivity as a mental health disorder?	3.72	62%
8	I believe that clinicians categorize social isolation as a mental health disorder?	3.63	56%
4	I believe that clinicians categorize alcoholism as a mental health disorder?	3.64	55%
16	I believe that clinicians categorize persons showing signs of chronic homelessness by moving frequently are showing mental imbalance tendencies?	3.48	45%
11	I believe that clinicians have concluded a shorter life expectancy for persons diagnosed with a mental health disorder?	3.47	51%
13	I believe that my church provides contact information on various health organizations that provide mental health services?	3.48	45%

Note: The scores are averages based on a total of 33 participants. They responded using a Likert scale of 1-5 (5=strongly agree; 4=agree; 3=not sure; 2=disagree; and 1=strongly disagree).

On Question 1, “I believe that clinicians categorize depression as a mental health disorder.” The average rating was 4.30 out of a possible 5.0 and 91% of the participants agree or strongly agree that clinicians believe depression is a mental health disorder. The participants clearly appeared to recognize depression as an issue and as a mental health challenge.

On Question 12, “I believe that mental health professionals have established services that will aid a person with a mental health crisis.” The average rating was 4.23 out of a possible 5.0 and 81% of the participants agree or strongly agree that mental health professionals have established services that will aid a person with a mental health crisis. There was solid agreement on this issue.

On Question 14, “I believe that physicians categorize mental health as a vital part of overall wellness.” The average rating was 4.22 out of a possible 5.0 and 84% of the participants agree or strongly agree that physicians categorize mental health as a vital part of overall wellness. The participants seemed to realize that mental health relates to overall health.

On Question 10, “I believe that clinicians have developed treatments for mental health disorders that allows the person to function in society.” The average rating was 4.19 out of a possible 5.0 and 81% of the participants agree or strongly agree that clinicians have developed treatments for mental health disorders that allows the person to function in society. The participants seemed to recognize that help is available for mental disorders.

On Question 9, “I believe that clinicians categorize continuous anxiety as a mental health disorder.” The average rating was 4.09 out of a possible 5.0 and 88% of the participants agree or strongly agree that clinicians categorize continuous anxiety as a mental health disorder. There was definite agreement that continuous anxiety is a mental health issue.

On Question #3, “I believe that clinicians categorize overeating as a mental health disorder.” The average rating was 3.85 out of a possible 5.0 and 70% of the participants agree or strongly agree, 21% of the participants, are not sure and 9% disagree or strongly disagree that clinicians believe overeating is a mental health disorder. Participants expressed less certainty than on previous item; yet they did recognize this as a mental health issue. Perhaps, not enough is being done to impact the beliefs of the community on overeating. This requires further investigation.

On Question 5, “I believe that clinicians categorize drug addiction as a mental health disorder.” The average rating was 3.79 out of a possible 5.0 and 70% of the participants agree or strongly agree, 18% of the respondents are not sure and 12% of the respondents disagree or strongly disagree that clinicians categorize drug addiction as a mental health disorder. Moreover, one may conclude that drug addiction is an acceptable illness with a strong support system or that drug addiction is moving toward an acceptable medical ailment.

On Question 2, “I believe that clinicians categorize hoarding as a mental health disorder.” The average rating was 3.76 out of a possible 5.0 and 67% of the participants agree or strongly agree, 21% of the respondents are not sure

and 12% of the respondents disagree or strongly disagree that hoarding is a mental disorder. For the participants who disagree or strongly disagree, perhaps hoarding is an acceptable illness that generates a lot of attention and keeps them attached to things they see as valuable. For the participants who are not sure, perhaps hoarding is moving toward a more acceptable medical ailment because they know several people that would fall into that category. I would wrestle with this issue if I had not seen first-hand the devastation when a clean-out of a home is done. Further evaluation is required.

On Question 7, “I believe that clinicians categorize sexual addiction as a mental health disorder.” The average rating was 3.75 out of a possible 5.0 and 59% of the participants agree or strongly agree, 28% of the participants are not sure and 13% of the participants disagree or strongly disagree that clinicians categorize sexual addiction as a mental health disorder. For the participants that disagree or strongly disagree, perhaps sexual addiction is not an illness; it is the desired method to procreate. For the participants that are not sure, perhaps they are wrestling with how sex can even become addictive or is that behavior a mental ailment. This requires further investigation.

On Question 6, “I believe that clinicians categorize attention deficit hyperactivity as a mental health disorder.” The average rating was 3.72 out of a possible 5.0 and 62% of the participants agree or strongly agree, 21% of the participants were not sure and 16% of the participants disagree or strongly disagree that clinicians categorize attention deficit hyperactivity as a mental health disorder. Conceivably, participants may believe that attention deficit

hyperactivity is a common childhood related diagnosis with a strong support system. Sometimes when everyone is talking about the same thing, we miss the devastation because what we see and hear is acceptance.

On Question 8, “I believe that clinicians categorize social isolation as a mental health disorder.” The average rating was 3.63 out of a possible 5.0 and 56% of the participants agree or strongly agree, 25% of the participants were not sure and 19% of the participants disagree and strongly disagree that clinicians categorize social isolation as a mental health disorder. Perhaps social isolation is something the participants are not familiar with or unclear at what point it becomes unhealthy. Possibly, respondents are not sure and more educational information is needed.

On Question 4, “I believe that clinicians categorize alcoholism as a mental health disorder.” The average rating was 3.64 out of a possible 5.0 and 55% of the participants agree or strongly agree, 24% of the participants are not sure and 21% of the participants disagree or strongly disagree that clinicians categorize alcoholism as a mental health disorder. Perhaps, since alcoholism is so common with such a strong support system, it is now seen as a medical or psychological ailment.

On Question 16, “I believe that clinicians categorize persons showing signs of chronic homelessness by moving frequently are showing signs of mental imbalance.” The average rating was 3.48 out of a possible 5.0 and 45% of the participants agree or strongly agree, 45% of the participants are not sure and 10% of the participants disagree or strongly disagreeing with clinicians that

categorize persons showing signs of chronic homelessness by moving frequently are showing signs of mental imbalance. There is neither clear agreement either way about chronic homelessness. Being homeless is no longer shameful and support systems and resources are growing to support the homeless. Furthermore, all of the coverage surrounding affordable housing may overshadow the real disease of mental illness. As homelessness becomes more acceptable, additional information on the devastating effects of chronic homelessness is needed. Further investigation is required.

Question 11, “I believe that clinicians have concluded a shorter life expectancy for a person diagnosed with mental health disorders.” The average rating was 3.47 out of a possible 5.0 and 51% of the participants agree or strongly agree, 36% of the participants are not sure and 13% of the participants disagree or strongly disagree that clinicians have concluded a shorter life expectancy for persons diagnosed with a mental health disorder. Almost half of the respondents are not sure, disagree or strongly disagreeing that mental illness is associated with a shorter life expectancy. Thus, additional information on the impact of life expectancy with a serious mental illness is needed.

On Question 13, “I believe that your church provides contact information on various health organizations that provide mental health services.” The average rating was 3.13 out of a possible 5.0 and 41% of the participants agree or strongly agree, 28% of the participants are not sure and 31% of the participants disagree or strongly disagree that churches provides contact information on various health organizations that provide mental health services.

Over half of the respondents are not sure, disagree or strongly disagree that mental health resources are provided by the church. Moreover, one-third of the respondents say distribution of information is not being done. Perhaps church support ministry training is needed along with workshops on mental wellness. Perhaps church ministries could aid in ridding churches of the stigma connected with mental illness.

Table 4: Attitude (Not Sure)

	Questions	Weighted Average Rating	Percentage of Participants Not Sure
15	I believe that clinicians categorize mental health conditions as hereditary?	3.23	45%

Note: The scores are averages based on a total of 33 participants. They responded using a Likert scale of 1-5 (5=strongly agree; 4=agree; 3=not sure; 2=disagree; and 1=strongly disagree).

On Question 15, “I believe that clinicians categorize mental health conditions as hereditary.” The average rating was 3.23 out of a possible 5.0 and 45% of the participants are not sure, 39% of the participants agreed and strongly agreed and 16% of the respondents disagreed or strongly disagreed that clinicians categorize mental health conditions as hereditary. Perhaps participants were not clear if heredity was attached to all mental disorders or just some disorders. Moreover, the data suggests there is insufficient education on the subject of mental illness being hereditary. Further investigation is required.

Summary

The following questions: 3 (over eating), 5 (drug addiction) and 2 (hoarding), informs us that 30% to 33% of the survey respondents lack knowledge on the three categories which impacts attitudes on overeating, drug addiction and hoarding. Respondents may believe that the three ailments are always about choice; and not due to a mental instability. Church support ministries would open the door to discussions on mental and physical wellness.

In analyzing questions 7 (sexual addiction), 6 (attention deficit hyperactivity), 8 (social isolation), 4 (alcoholism), we find that 38% to 45% of the survey respondents are not sure, disagree and strongly disagree that clinicians categorize the ailments as mental health disorders. On the other hand, 55% to 62% of the participants agree and strongly agree that clinicians categorized them as mental health disorders. We are almost split down the middle. As the ailments become more common, additional information on the devastating effects is needed.

In reviewing (11) life expectancy, (13) church providing information on health care services, (16) chronic homelessness and (15) mental health being hereditary, additional study is needed. In looking at the following questions: (1) depression, (12) relevant treatment for mental illness, (14) mental health as overall wellness, (10) establishment of mental health services and (9) anxiety disorder, participants are aware of these disorders and services. Participants seemed to be informed about these areas. Perhaps there are grounds for some hope as to church member's awareness and sensitivity.

Goal #4: Discover the actions

The fourth goal is to discover the actions of the parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME).

Table 5: Actions (Agreement)

Questions		Weighted Average Rating	Percentage of Participants (Strongly Agree and Agree)
13	I am willing to engage in ministries that help churches provide contact information on organizations that provide mental health services.	3.94	87%
15	I am willing to work with others in developing church ministries to provide written educational material on mental health.	3.90	81%
1	I am willing to participate in ministries that help people who are depressed.	3.72	69%
8	I am willing to participate in ministries that help people who engage in social isolation.	3.72	66%
16	I am willing to work with others in developing partnerships with homeless support groups for persons showing signs of chronic homelessness.	3.68	68%
14	I am willing to engage in ministries that help people with their overall mental wellness.	3.64	70%
3	I am willing to participate in ministries that help people who over eat.	3.63	59%
2	I am willing to participate in ministries that help people who hoard.	3.50	56%
12	I am willing to engage in ministries that will aid a person with a mental health crisis.	3.43	63%
9	I am willing to participate in ministries that help people who experience continuous anxiety.	3.42	55%
4	I am willing to participate in ministries that help people who are alcoholics.	3.41	53%
5	I am willing to participate in ministries that help people who have drug addictions.	3.38	53%
6	I am willing to participate in ministries that help people who have attention deficit hyperactivity.	3.31	50%
11	I am willing to participate in ministries that help people diagnosed with mental health disorders.	3.29	55%
10	I am willing to participate in ministries that help people with mental health disorders function in society.	3.28	53%

Note: The scores are averages based on a total of 33 participants. They responded using a Likert scale of 1-5 (5=strongly agree; 4=agree; 3=not sure; 2=disagree; and 1=strongly disagree).

On question 13, “I am willing to engage in ministries that help churches provide contact information on organizations that provide mental health services.” The average rating was 3.94 out of a possible 5.0 and 87% of the respondents agree or strongly agree that they are willing to engage in ministries that help churches provide contact information on organizations that provide mental health services. Participants seem to express a positive willingness to be a part of helping those with mental illness by distributing appropriate information.

On question 15, “I am willing to work with others in developing church ministries to provide written educational material on mental health.” The average rating was 3.90 out of a possible 5.0 and 81% of the participants agree or strongly agree with working to develop church ministries to provide written educational material on mental health services. Helping create educational material is another way these participants seem to be willing to help.

On question 1, “I am willing to participate in ministries that help people who are depressed.” The average rating was 3.72 out of a possible 5.0 and 69% of the participants agree or strongly agree, 15% are not sure and16% disagree and strongly disagree to participate in ministries that help people who are depressed. A little over two-thirds of participants expressed some willingness to assist depressed people. Perhaps this is an area they are more familiar or comfortable with. Perhaps the participants believe there is such a strong support system for depression, those that are not sure and disagree and strongly disagree do not think they can add anything. Maybe a church ministry lead by

those who suffer with depression could help those that are struggling should be investigated.

On question 8, “I am willing to participate in ministries that help people who engage in social isolation.” The average rating was 3.72 out of a possible 5.0 and 66% of the respondents agree or strongly agree, 30% are not sure and 4% disagree and strongly disagree to participate in ministries that that help people who engage in social isolation. Around two-thirds of participants expressed some willingness to help those with social isolation issues. Church ministries that engage members are perhaps something that should be investigated. Perhaps more education is required on social isolation and maybe ministries would be helpful.

On question 16, “I am willing to work with others in developing partnerships with homeless support groups for persons showing signs of chronic homelessness.” The average rating was 3.68 out of a possible 5.0 and 68% of the respondents agree or strongly agree, 26% are not sure and 6% disagree and strongly disagree to work with others in developing partnerships with homeless support groups for persons showing signs of chronic homelessness. Here again about two-thirds of respondents experience some willingness to help with homeless support groups. A solid majority of participants indicated a will to help others with general or overall mental illness. Perhaps for those that are not sure, more education is required on homelessness and the type of wrap around services that are available. Perhaps more information could create ministry opportunities within the church such as veterans helping veterans.

On Question 14," I am willing to engage in ministries that help people with their overall mental wellness." The average rating was 3.64 out of a possible 5.0 and 70% of the respondents agree or strongly agree, 20% are not sure and 10% disagree and strongly disagree about being willing to engage in ministries that help people with their overall mental wellness. A solid majority of participants indicated a willingness to help others with general overall mental wellness. Perhaps the question needs to be restated to focus on a specific ailment and more education is required on mental wellness. The question may imply that we needed professional help at all times. Possibly, complete an investigation on ministries concerning physical health, stress release, budgeting that also help with overall mental wellness.

On question 3, "I am willing to participate in ministries that help people who over eat." The average rating was 3.63 out of a possible 5.0 and 59% of the participants agree or strongly agree, 25% are not sure and 16% disagree and strongly disagree that they are willing to participate in ministries that help people who over eat. A majority of participants expressed some willingness to help people with eating disorders. Perhaps more education is required on overeating and maybe respondents are not sure ministries would be helpful with so many resources available. Church ministries on health and wellness support groups, which include diet and exercise classes, perhaps should be investigated.

On question 2, "I am willing to participate in ministries that help people who hoard." The average rating was 3.50 out of a possible 5.0 and 56% of the participants agree or strongly agree, 28% are not sure and 16% disagree and

strongly disagree that they are willing to participate in ministries that help people who hoard. Willingness to help in this area is not as strong as in the previous area. Perhaps more education is required on hoarding and perhaps they are not sure ministries would be helpful.

On question 12, “I am willing to engage in ministries that will aid a person with a mental health crisis.” The average rating was 3.43 out of a possible 5.0 and 63% of the participants agree or strongly agree, 17% are not sure and 20% disagree and strongly disagree that they are willing to participate in ministries that help people with mental health crisis. The question may lead you to believe that you are not equipped to handle a crisis or you are just not sure. Perhaps more education is required on aiding when there is a mental health crisis.

On question 9, “I am willing to participate in ministries that help people who experience continuous anxiety.” The average rating was 3.42 out of a possible 5.0 and 55% of the participants agree or strongly agree, 32% are not sure and 13% disagree and strongly disagree to participate in ministries that help people who experience continuous anxiety. This willingness to help people with continuous anxiety issues “was” positive but not very strong. For those that are not sure, perhaps more education is required on anxiety and perhaps they are not sure ministries would be helpful.

On question 4, “I am willing to participate in ministries that help people who are alcoholics.” The average rating was 3.41 out of a possible 5.0 and 53% of the respondents agree or strongly agree, 25% are not sure and 22% disagree and strongly disagree that they are willing to participate in ministries that help

people who are alcoholics. In any case, the willingness to help in this area did not seem to be very strong. Perhaps respondents believe there are sufficient support systems available.

On question 5, “I am willing to participate in ministries that help people who have drug addictions.” The average rating was 3.38 out of a possible 5.0 and 53% of the respondents agree or strongly agree, 47% are not sure and disagree and strongly disagree that they are willing to participate in ministries that help people who have drug addictions. Participants did not seem to be very eager to help others who have drug addictions. Perhaps more education is required on drug addictions and perhaps they are not sure ministries would be helpful with so many resources available.

On question 6, “I am willing to participate in ministries that help people who have attention deficit hyperactivity.” The average rating was 3.31 out of a possible 5.0 and 50% of the participants agree or strongly agree, 28% are not sure and 22% disagree and strongly disagree to participate in ministries that help people with attention deficit hyperactivity. Participants did not seem to be very drawn to helping in this area. Perhaps more education is required on attention deficit hyperactivity and perhaps they are not sure church ministries would be helpful with so many resources available.

On question 11, “I am willing to participate in ministries that help people diagnosed with mental health disorders.” The average rating was 3.29 out of a possible 5.0 and 55% of the participants agree or strongly agree, 22% are not sure and 23% disagree and strongly disagree with participating in ministries to

aid those diagnosed with mental health disorders. There was not much enthusiasm for helping in this area. Mental health disorder may have been too broad and perhaps the question could be restated to identify the mental health challenge. With more education maybe new ministries could be birthed, as some respondents may not see themselves as qualified to offer aid.

On question 10, “I am willing to participate in ministries that help people with mental health disorders function in society.” The average rating was 3.28 out of a possible 5.0 and 53% of the respondents agree or strongly agree, 25% are not sure and 22% disagree and strongly disagree that they are willing to participate in ministries that help people with mental health disorders function in society. There was little agreement to help people function in society. Maybe they were unclear on what this was. Perhaps more education is required and perhaps they are not sure ministries would be helpful.

Table 6: Actions (Not Sure)

Questions		Weighted Average Rating	Percentage of Participants Not Sure
7	I am willing to participate in ministries that help people who have sexual addictions.	3.0	41%

Note: The scores are averages based on a total of 33 participants. They responded using a Likert scale of 1-5 (5=strongly agree; 4=agree; 3=not sure; 2=disagree; and 1=strongly disagree).

On question 7, “I am willing to participate in ministries that help people who have sexual addictions.” The average rating is 3.00 out of a possible 5.0 and 41% of the respondents were not sure, 31% agreed and strongly agreed and 28% disagreed and strongly disagreed to participate in ministries that help

people who have sexual addiction. The average of 3.0 expressed uncertainty in willingness to help with sexual addictions. Participants expressed the lowest degree of willingness to participate in this area than any of the other areas. My observations say very little movement toward developing ministries on sexual addiction has taken place. Perhaps, additional education is needed.

Summary

The survey results showed the willingness of participants to work in ministries with 97% to 53% that strongly agreed and agreed to participate. This is very encouraging and it shows that church members are seeing a need to aid those who experience mental health challenges. Yet there were thirteen questions where the survey result showed at least 30% to 47% that were not sure, disagreed and strongly disagreed with participating in ministries or developing support ministries. The survey results showed that 30% to 37% were not sure, disagreed or strongly disagreed to participate in ministries for the following mental disorders: depression (#1), social isolation (#8), mental health crisis (#12), overall mental wellness (#14) and homeless support groups (#16). In addition, the survey results showed that 41% to 47% were not sure, disagreed or strongly disagreed to participate in ministries for over eating (#3), hoarding (#2), alcoholism (#4), drug addictions (#5), continuous anxiety (#9), diagnosis with a mental health disorders (#11) and functions with a mental health disorders (#10). Moreover, the survey results showed that 50% were not sure, disagreed or strongly disagreed to participate in ministries for those with attention deficit

hyperactivity (#6). Again, action or lack of action is sometimes driven by how much we know about an issue.

Observations from the data suggests that the more acceptable the diagnosis, the less lightly the desire to work in ministries because it could be believed it is not needed. Strong support systems are also a possible reason that church ministries are not developed. Church ministries could investigate the wrap around services for mental health to start new support ministries or investigate partnering with other support groups.

Goal Number #5: Evaluate the Study

The fifth goal was to evaluate the study.

Table 7: Evaluate the Study

	Questions	Average Rating	Percentage of Participants (Strongly Agree and Agree)
4	This study should be made available to all churches seeking to establish mental wellness ministries.	4.29	96%
5	This study enlightened me about the importance of mental wellness ministries in churches.	4.11	82%
2	This study allowed me to express my feelings about how churches minister to those with mental health challenges.	4.00	90%
3	This study increased my understanding of mental illness.	3.75	68%
1	This study is helpful to me.	3.72	83%

Note: The scores are averages based on a total of 33 participants. They responded using a Likert scale of 1-5 (5=strongly agree; 4=agree; 3=not sure; 2=disagree; and 1=strongly disagree).

On question 4, “This study should be made available to all churches seeking to establish mental wellness ministries.” The average rating was 4.29 out of a possible 5.0 and 96% of the respondents agree or strongly agree that the study should be made available to other churches seeking to establish mental health ministries. This area received the highest average rating of any of the evaluation topics. This suggests that participants viewed the study as a valuable resource.

On question 5, “This study enlightened me about the importance of mental wellness ministries in churches.” The average rating was 4.11 out of a possible 5.0 and 82% of the respondents agree or strongly agree that the study highlighted the importance of mental wellness ministries in churches. This suggests participants saw the project as beneficial, in that they learned about the importance of mental health from being a part of the study.

On question 2, “This study allowed me to express my feelings about how churches minister to those with mental health challenges.” The average rating was 4.00 out of a possible 5.0 and 90% of the respondents agree or strongly agree that it allowed a person to express their feelings about how churches minister to those with mental health challenges. This suggests the study helped participants express themselves in a beneficial way.

On question 3, “This study increased my understanding of mental illness.” The average rating was 3.75 out of a possible 5.0 and 68% of the respondents agree or strongly agree, 29% are not sure and 3% disagree and strongly

disagree that the study increased their understanding of mental illness. This suggests for those that were not sure, perhaps more education is required.

On question 1, “This study is helpful to me.” The average rating was 3.72 out of a possible 5.0 and 83% of the participants agree or strongly agree that the study was helpful. This area received the lowest rating of all the areas assessed. Since the survey was designed to measure rather than to teach, perhaps the participants’ reactions indicate they need more information. In any case, the results reveal that participants were not just agreeing with everything.

Summary

The evaluation questions all focused on how the inquiries allowed the respondent to think about mental illness in a different way with the focus on change and ministry. Questions 4, 5, 2 and 1 were about measuring how knowledge and/or what we believe can help us change our attitudes and actions. In the end, the response to question #3, “This study increased my understanding of mental illness,” received a 68% response ratio of participants who agreed or strongly agreed. One third of the respondents are not sure, disagreed or strongly disagreed that their understanding increased. My observation is that more information on mental health is needed.

Overall, there is still a need to educate on what is mental illness, what type are resources are available and the importance of support groups. Under knowledge, eleven (11) of the sixteen (16) questions, respondents that were not sure ranged from 21% to 58%. Under attitudes, ten (10) of the sixteen (16)

questions, respondents that were not sure ranged from 21% to 45%. Under actions, twelve (12) of the sixteen (16) questions, respondents that were not sure ranged from 20% to 41%. When mental health is so important to the quality of life, so many people are still not sure what are mental ailments, what it does to the body and the impact it has on others.

CHAPTER SIX

SUMMARY AND REFLECTIONS

Mental illness is not a discriminatory ailment. It is an equal opportunity disease that knows no race, skin color, gender, familial status, sexual orientation, national origin or station in life. When one is diagnosed with a mental health concern, it is concluded that somehow someone has failed to “navigate living life” and fails in becoming a contributing part of society. Mental illness has been described as living life on a roller coaster where life is up and down and constantly moving without your control. The ride never stops; therefore, the rider cannot get off and every day you are trying to hold on and not fall or fail; but just live. A byproduct of the chaos in trying to live a normal life is the fear found in everyday existence.

Not only has crippling fear taken residence in the person’s mind, that same fear finds its way into the actions of family and the church. Whether the action is good or bad, it causes everyone to question and justify their behavior. In living with the disease, being the support person for a family member and being a member of a loving and caring church; in the end, it becomes difficult to discern and separate ‘reality of what is’ from the ‘reality of what is perceived’. The person with the disease dies a slow death due to lack of knowledge and unfounded fear of well-meaning people. The family members will start to question their own mental strength to provide assistance and the church remains silent and appears to walk away and offer no support. Fonda Bryant tells us from the National

Alliance on Mental Illness (NAMI) in *You Can't "Pray Away" A Mental Health Condition,* that:

> African-Americans are the most religious culture in the United States. Our deep-rooted religious beliefs go all the way back to slavery, when religion was the one solid foundation we had during those times. Our ancestors then—like we African-Americans now—lived with depression, anxiety, bipolar and PTSD but back then, there weren't any names for those conditions. Back then, people battling a mental health condition were simply locked up, wandered the streets or even put to death. With all that my culture had to deal with throughout history, present-day African-Americans feel we don't need help mentally. All we need to do today is the same our ancestors did, which is: "Pray about it. Give it to God." But you wouldn't tell someone with cancer, diabetes or heart problem to just pray about it or give it to God, would you? You'd hopefully say: "You need to see a doctor." But when it comes to mental health in the African-American community, there is very little compassion or empathy. (Bryant 2018)

Where do we go from here? The conclusions drawn from the results of the analysis of the survey respondents and from the secondary literature leads me to this question: Do we create a "separate but equal prison," an "environment of parallelism" for those with mental health concerns like the Gerasene demoniac, and provide comfort to the family that the person is not roaming the streets or do we establish support ministries that aid in establishing a network of assistance? How do we move forward and take away the power of fear?

Project Goal(s)

The focus of my project was to discover the knowledge, attitudes and actions of parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME). The specific goals that were used to evaluate the success of the project are as follows:

1. Collect primary and secondary material on various forms of mental illness, mental health and mental wellness.
2. Create a survey for distribution to discover the knowledge, attitudes and actions of parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME).
3. Distribute and collect the survey; as well as, use an online survey application to analyze the data.
4. Analyze and evaluate material.
5. Document the findings.
6. Evaluate the study.

Based on the initial data collected and evaluated for each of the goals, it was demonstrated that Goal #1, Collect primary and secondary material on various forms of mental illness, mental health and mental wellness was the most prominent. It was then followed by Goal #2, Create a survey for distribution to discover the knowledge, attitudes and actions of parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME). Goal #3, Distribute and collect the survey; as well as, use an online survey application to analyze the data followed. Goal #4 was Analyze and evaluate material. Goal #5, was Document the findings. Lastly, was Goal #6, Evaluate the study.

The discovery of the knowledge, attitudes and actions of parishioners about ministering to the mentally ill was revealed in evaluating the study. While analyzing the data was important so was the survey tool with the questions that allowed us to probe for the knowledge, attitude and actions of the participants concerning the mentally ill. The primary and secondary literature helped me to understand the places, struggles and trials the families found themselves in while trying to navigate the journey with their family member. Distributing the survey tool helped me to understand why some people did not take the survey and lastly, the process aided me in documenting the findings. The entire experience expanded my knowledge on how dealing with the disease mean constant involvement, continuous education and developing strong support systems in and out of the church; plus identifying resources that are critical to a person's quality of life.

Goal # 1: Collect and Evaluate the Primary and Secondary Literature

Goal #1 was to collect primary and secondary material on various forms of mental illness, mental health and mental wellness. Collecting information was a journey that lead me to ask myself, how do you help when you do not know the problem? Where do you start, if you do not know what is happening with the person? Collecting and reading books and articles on mental health, lead to reading about help for mental illness; which lead to reading how lives were changed when aid was provided. When all you know is that the doctors have provided a mental health diagnosis and you do not know what happens next,

especially when the medication does not work, you are lost. The secondary literature showed the path of wellness for others. Just seeing how others dealt with mental health challenges allowed me to see that we were not alone and the shame of the illness came from hiding in fear. The research revealed that there was a lot of information and assistance available for a person with a mental health challenge, but there was also still a void because the church was not present.

Goal # 2: Create Survey Tool

Goal # 2 was to create a survey for distribution to discover the knowledge, attitudes and actions of parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME). The survey became the tool to explore not only what the experts in the field of mental illness had to say, but it was also used to expand my knowledge which will lead to expanding my world. The survey allowed me to document what I believed, inquire about what I did not know and ask questions about what the respondents knew, thought and was willing to do, concerning mental health. The tool allowed others to open up about mental health issues that they agreed with and those that they thought were not valid. The survey became my way of asking questions and starting conversations on mental health.

Goal # 3: Survey Distribution and Analysis

Goal #3 was to distribute and collect the survey; as well as, use an online survey application to analyze the data. The distribution of the survey was not a concern because at a Cleveland District meeting everyone was willing to help by taking a survey. But, returning the survey was the challenge. Even when the survey was distributed at the beginning of a meeting and collected at the end of the meeting; or even collected during lunch, the results of return were less than expected. Emailing the survey to the pastors and lay leaders did not get the desired response and only two surveys were returned via email. The slow response rate could be attributed to survey questions that identified mental health challenges that maybe respondents were not familiar with, ignoring, or not sure of some ailments listed; such as hoarding. Maybe the privacy of information was not clear enough for the participants. Possibly the survey was too long. On the positive side, I got to have a lot of general conversations on mental health.

Since the proposal was discovering the knowledge, attitudes and actions of the parishioners of the AME Church in the Cleveland District on mental illness, additional information on the respondents to the survey would have been helpful. Connecting the demographics of the survey participants to age, leadership status in the church, participations in various ministries in the church and the role that a person played in worship would have identified patterns associated with age and identified those who had not been exposed to forward thinking or acceptance of the disease. Identifying ways to unpack built in prejudices and fear could help in

determining why the black church and the AME church in particular, shies away from providing assistance to members with mental health concerns.

Goal # 4: Analyze and Evaluate Material

Goal #4 was to analyze and evaluate material. How can those of us, members of the Christian faith, that are called to love and treat others as we would want to be treated, willingly aid in creating a separate and unequal environment for others? To be part of the paradigm shift for the mentally ill, to acknowledge a “new normal,” where all people are included and all people are valued would require a new vision of seeing all people through the eyes of Jesus.

Additional literature on the subject matter opened up different perspectives on mental health. In evaluating where I started and where I am presently, I would say I have changed because of the discovery of new information that reshaped my attitude and provided me the opportunity to understand different views on how to support a person diagnosed with the disease. This is an awesome accomplishment because it opened the door to a pathway of wholeness and restoration for my family. Acceptance of his mental illness has begun to shift with the willingness of family to engage in conversations, whether positive or negative concerning the disease. The family now includes my brother in the conversations and we listen to his treatment plan, which includes support groups and medication. Now, we can talk about mental health challenges and listen to conversations that are now being distributed by mass media with billboards that identify warning signs of needing mental health support, TV advertisements with

more pharmaceutical companies openly providing information on medications that are available to help stabilize a person's mental health. Now, most of the family participates in the conversations with no fear.

Analyzing and evaluating the data to a 'lived reality' opened my eyes and mind to other real struggles and how and when God showed up. Are we all crazy and just do not know it? Do we all have a "new normal" that has become our 'lived reality' of our everyday existence? We have come to accept behavior and we do not know if it is normal or odd. In reviewing the secondary literature, the more I realize there is more for me to read and learn about mental health. The more I came across things that I had not considered before, the more I needed to evaluate the data. The literature brought life to the patients and what their needs were, such as church support groups and a strong faith. In reviewing the data, it became clearer that survey respondents needed additional information, especially in the knowledge section that had a focus on the definitions of mental illness. The participants frequently responded with "not sure"; which indicates that more emphasis should be applied to educating the church and community on the challenges of mental illness.

The findings from the survey painted a positive picture of change in the church with a focus on acceptance of mental health disorders that has allowed for more frequent engagement in educating ourselves and others plus opening the door to embracing partner resources and learning how to provide support to the person and their family.

Goal # 5: Document Findings

Goal #5 was to document the findings. A great deal of time was spent defining mental illness, mental health challenges, reviewing the meaning of theology and connecting the scripture for the project. It became very important to keep things in the proper context so that the focus and energy was on how to address the lack of knowledge concerning mental illness; how to guide actions that impact attitudes, especially those that are more detrimental than helpful within the church. Documenting findings allowed me to further engage others in conversations about mental health, especially where there was an ailment like social isolation that most people were not familiar with. It also opened up conversations with the AME churches on the need for support ministries.

The AME church in the Cleveland District has taken some steps with increased focus on awareness of depression and suicide prevention. Both diseases have slowly crossed over into acceptable forms of mental health conditions within the church. This progress was mostly due to an increase in education on awareness, resulting from an increase in workshops on the subject and resulting in people acknowledging they are suffering with depression and having suicidal thoughts. This breakthrough has led to the subtle acceptance of other forms of mental illness, such as bi-polar disorder. With more open and honest discussions, the door is not completely shut on dialog surrounding other mental ailments that are not so easily accepted, such as paranoid schizophrenia. Today, in general, mental

health challenges are evolving and only becomes a “separation for life sentence” if the disease is not understood.

Goal # 6: Evaluate Study

Goal # 6 was to evaluate the study. For many in ministry, it is easy to shy away from ministering to the needs of the whole person. I found it difficult to be detached from a love one; which made it very problematic for me to close my eyes to church people and mental illness as an incurable disease that leaves a person ostracized. Daily living changed for the person who has been diagnosed, family members made adjustments in interactions, resulting in isolation within the family and your church that is now saying, “you are not welcomed”. Being intentional about understanding and being inclusive made a difference in family behavior and was the catalyst for other family members to be open to the acceptance of the disease.

The evaluation of the study was a journey of discovery that led me to encounter many people who hide their mental illness as opposed to seeking professional help or support from their church. In my project, the guiding scripture was Mark 5:1-20, known as the Gerasene demoniac. In that scripture is where I immersed myself into the biblical, theological and historical perspective that guided the belief and action of those who suffer with a mental health issue. The journey of the Gerasene demoniac opened my mind to the real possibility of restoration, no matter the mental ailment. Encountering those that have given up on being accepted in their church,

family, and community; and have chosen to become spectators in living life in a ‘man-made prison’, is becoming common, due to not believing in what God can do. For those who are called to ministry, we also became spectators because we look from afar, pass judgement without the benefit of fact finding. Moreover, we do not engage in any effort towards positive change in the church’s acceptance of mental illness. The evaluation leads us to continue the journey with more education on the various forms of mental illness, which is necessary to effect real change.

The survey results identified that the respondents want to become more engaged in ministry to support those within the church with mental health disorders. It also revealed that continued education is needed to aid church members in understanding that there are multiple mental health disorders that require different approaches. Shortcomings such as mental health resources shared by the church needs to take steps to improve information distribution. Also, the value of support ministries and mental wellness evaluation are a key component to improving the quality of life of all that are impacted by mental health disorders.

Application

Where do I go from here? The demoniac is a man that does not relate to society because of his present environment which has become oppressive due to his circumstances and how he is viewed by his community. The lessons learned from the survey will help the church move forward in the direction of inclusion

and acceptance of all, hopefully shifting how those with mental health challenges are received. I am using my ministry to implement ways to provide support for families that deal with the challenges of a loved one who has a mental illness.

Using results from the survey, more church members are willing to become engaged and one way is with ministry support groups on various mental health disorders. Expanding support groups will increase educational chances and provide additional opportunities for ministry. There are many reasons, several concerns and numerous things that each of us must deal with in just living life. Juggling all of the things that life hands us, without a solid support system could have negative consequences that result in a person withdrawing from the problem and society. My focus will include active engagement of church members, utilizing partners with resources and continuing to build upon education, which is key. All must work together so that the church is not a judgmental and uninviting environment for a person dealing with a mental illness.

My ministry is a call to serve, a call to embrace, a call to lift up and a call to transform. I am using my ministry to develop ways to provide support for families that are adjusting to and embracing the changes of a loved one who has a mental disorder and is fighting for inclusion. The implementation of family support groups to discuss the struggles that come with having a loved one with a mental health disorder; in addition to the traditional support groups for alcoholics anonymous and drug addictions, will be started. Will also work on developing support groups to identify early warning signs of hoarding. In addition, I will make sure that my church will have referral information for those with mental health

challenges. I will work to partner with other local congregations to develop support programs for those diagnosed with a mental health disorder and develop support ministries for family members to expand the church's reach; knowing that one size does that fit all.

Knowing that everyone needs a supportive environment, will work to develop ministries of presence, which says that everyone needs someone to talk with and walk with during a mental health crisis. My ministry will support and encourage engagement of the family unit in worshiping together; along with educational workshops on mental wellness and how to embrace the differences in each other. Matthew 25:40 says, "And the King will say, 'I tell you the truth, when you did it to one of the least of these my brothers and sisters, you were doing it to me" (NLT-New Living Translation). The mentally ill are considered members of the "least of these." The word of God will be our change agent to guide acceptance of all.

Further Study

"What am I to do Lord?" Acts 22:10 (NIV) There are ministries for addictions, homelessness, financial literacy, and job readiness; just to name a few. Further study needs to be continued with a focus on interventions that address the residual impact of the prolonged effects of not dealing with mental health disorders that manifest due to violence in the home and community, birth ailments such as drug addictions, disorders due to family abandonment and incarceration and poverty. The church should convene working groups on how to

deal with mental health disorders that impact all our children including teenagers and young adults. In addition, further study should be done on how support ministries could aid members and families in dealing with Alzheimer's and dementia as well as support for family members who are the caregivers. Additional education is needed on the various medications prescribed to those with mental disorders, as well as all of the known side effects.

What has caused the church to no longer see the possibility of "ministries of change, growth and acceptance" that made the AME church strong, as part of her mission when dealing with the mentally ill? For additional study, I would investigate the following: How to deliver messages that educate people on mental wellness? What type of support ministries should be put in place to support the person who has been diagnosed? What type of support ministries can be put in place to support families? What type of mental health resources are available in your service area? What is mental illness? How does one identify ministry gifts of the mentally ill?

With further study, look at where we stand as the AME connectional church and map out plans that creates acceptance within the church for those with mental health disorders. Also, conduct a review of the training curriculum for new ministers that come into the AME church to add a study track that covers at least one class per year for the four years of ministerial training, on how to embrace and minister to those with mental health disorders. The training curriculum should also include training on the multiple types of mental disorders. When the illness strikes, the person may never get a chance, within the church to

create a “new normal,” because of what is perceived to be normal for the average person never allows room for the possibility of a “new normal” attached to the change in behavior for that person within the church and community. Further study should be done on presenting workshops on how to accept and understand the various mental health challenges to continuously expand the churches’ knowledge.

Personal Goals

Mental illness is a crippling disease for most people in that it produces “doubt and fear of the unknown” in all that it touches; leaving a devastating trail of avoidance and isolation. The key to understanding mental illness is to understand the impact it has on everyday living and on acceptance or lack thereof, by your church, family and community. Acceptance is the key and is deeply rooted in the behavior of the church and the community.

My personal goals were as follows:

1. To obtain a better understanding of the various ways God intervenes in the life of those who suffer with mental illness.
2. To obtain a better understanding of the various ways God uses spiritual restoration for people that are sick.
3. To continue to educate myself and the church on how God’s instructions defines our actions in adjusting to change.
4. To work harder to preserve my own health so I can be a better pastor.

Personal Goal # 1: Understanding Ways God Intervenes

Personal Goal #1 was to obtain a better understanding of the various ways God intervenes in the life of those who suffer with mental illness. “The construction of our identity is not an abstract process in a vacuum; it is historically grounded in culture and involves a lot of emotions and feelings. For many it can be traumatic as we move from childhood to adulthood, if we do not find the support to be ourselves in the face of stressful or even harmful social and cultural expectations” (DeYoung 2009, 6). God’s intervention is continuous and it is present through all that we encounter. God intervened when he sends angels, sends family, to act on your behalf; God intervenes when he shows you how to love unconditionally and there is no crystal ball to predict the outcome; God intervenes with support systems in friends, doctors and support services which includes medication and God intervenes when he did not allow me to lose my mind but guided me in a new direction, which is what he did for my brother.

Research revealed that mental illness is all around us; it is a difficult life to live; and it will take a praying, spirit filled church and community, along with willing members to aid in making a difference in the life of the mentally ill. The primary and secondary literature was very enlightening in understanding how God intervenes and sends help when we are in crisis. God’s intervention lead me to seek help and through that process I was able to become stronger and help others when I started to rely on God to guide the process of learning about the various disorders, all of the different medications and what to do to help my

brother and myself. God intervened with the many conversations and discussions that I have had on mental health.

I believe that “God will never leave you nor forsake you.” God in the life of the person with a mental disorder allows that person to thrive in the midst of pain and doubt. God allows that person to see His glory in their struggle to develop a “new normal.” In that development process gifts are brought forward to help others and doors are opened that were once closed because we all can now see God.

Personal Goal # 2: Understanding Ways God Uses Spiritual Restoration

Personal Goal #2 was to obtain a better understanding of the various ways God uses spiritual restoration for people that are sick. To see God working today in the mind of the mentally oppressed is to see the favor of God. Through my research and findings, I can see the blessings of doctors, medical research, support people who are spiritually focused, individuals that are not afraid to tell their story, and the blessings of the Father through his Son Jesus that allows us to see God working today in the journey of the mentally challenged. Lives are changed with a “new normal” that allows the person to function with less fear or isolation; Gods restores them and life is made better.

God allowed me to understand that he works within every person for his good. Acceptance and following the will of God allowed us to see the spirit of the living God dwelling within my family. Family gatherings are more spiritual because we are all witnesses to the power of prayer, staying faithful and giving

your problems over to Jesus and to what it means to see a miracle. Even through the hurt and pain of the illness, Jesus was working in the life of my brother, He restored his mind to understand that his life would be better if he accepted the fact that change was happening and medication could help restore his mental balance. The mind will not set you free; and for the mentally challenged, who are lost within their mind, there is hope in Jesus. The change in my brother is a healing miracle.

Personal Goal # 3: Continue to Educate Myself and the Church

Personal Goal #3 was to continue to educate myself and the church on how God's instructions defines our actions in adjusting to change. From the scripture lesson, Mark 5:1-20, it is evident that God is powerful and the demons within the man are also powerful. The stronghold of mental illness is so powerful that the escape from the stigma becomes overwhelming and crippling. God changed the life of the demoniac, but the demon that lives within the mind of a person suffering with a mental disease is set free with God. Demons will bind you; mental illness will chain you, but God will set you apart, change you, and set you free. I will work to provide support groups that will help when one is stuck and stressed out; and when one cannot control all situations.

I will continue to witness to others in how God changed my life. God opened my mind and heart to see the new person and not the old person or what I thought the person should be. God allowed me to see the different gifts that were living inside of my brother and how God could use him to help others in his

family. My witness is how God molded him to become the person that God had a plan for. I witness to a journey that was hard but there was encouragement, education, love and support all along the way. I educated myself on the disease and ways to support others who are struggling. I read books and I give workshops on mental health to take away the power of the disease and empower others.

Personal Goal # 4: Preserve my health

Personal Goal #4 was to work harder to preserve my own health so I can be a better pastor. For this goal, I included my ministerial staff to teach bible study and preach at least once a month. I constantly remind myself that ministry is done with a team and not in a vacuum. I am bi-vocational and I delegate more and share the load with others and not just with Jesus. Every day, I spend time mediating and praying for restoration for all. Finally, I take time to work on my own mental health by taking time for rest and fun. I am doing my best to live a balanced life.

Concluding Thoughts

Mental illness is not a life ending sentence, but is the beginning of a “new normal” and the opening to allow Jesus to work a miracle in you. The first act of Jesus was to start the process of ridding the man of some of the issues that held him in bondage and to make a way for the man to return to wholeness. Because of Jesus’ selfless actions, this man became a wonderful witness to the miracles and saving power of Jesus. Even though the man was different, and even though

there is restoration for the demon possessed man; community acceptance was blocked by fear and wholeness within the community was still not within his reach. The AME church and the black church struggles with the presence of the mentally challenged. Even though we can acknowledge the illness and the road blocks created in our families, church and community, the black community still struggles with acceptance of mental illness and because we struggle, the resulting exclusion of any person creates “mental obstacles” that the person must overcome.

Mental health is an ongoing challenge because the mind is a powerful tool that can be used for positive or negative change. When reality is somehow distorted, life becomes the jailer and the person may want to unlock the door to living, but cannot because the mind’s distorted pattern of reasoning is controlling the opening and closing of the jail door while trying to also to sort out and define normalcy. It is at this point that the person starts to accept their present circumstances and find their way navigating to isolation. The mission for the AME church is to open the doors of the church to acceptance and love. The church is still the place where acceptance and encouragement are found, and Jesus is performing miracles.

God is always present. The question becomes, “Is the church still relevant to the changes within the community?” For every action, there is a reaction; and for every inaction there are consequences. We must ask the question again, historically, is the black church still aligned with the needs of the black community? The needs of the members of the church includes the pain and trials

of living life; which includes mental health. For the mentally ill, reminiscing about how great it use to be is often missed opportunities to make a change in the actions of the church. When one fails to see the community of believers, one fails to see the wealth in the assets; the people, the importance of the black church, and the greatness in the possibilities of change.

APPENDIX ONE

PROPOSAL

ASHLAND THEOLOGICAL SEMINARY

TO DISCOVER PARISHIONERS' KNOWLEDGE, ATTITUDES AND ACTIONS REGARDING MINISTERING TO THE MENTALLY ILL IN THE CLEVELAND DISTRICT OF THE AME CHURCH

A PROJECT PROPOSAL SUBMITTED TO
THE FACULTY OF ASHLAND THEOLOGICAL SEMINARY
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF MINISTRY BLACK CHURCH STUDIES

BY
LOUISE JACKSON

CLEVELAND, OHIO
JANUARY 23, 2018

THE PROPOSAL

TO DISCOVER PARISHIONERS'
KNOWLEDGE, ATTITUDES AND ACTIONS
REGARDING MINISTERING TO THE MENTALLY ILL IN THE
CLEVELAND DISTRICT OF THE AME CHURCH.

Purpose and Research Question

The purpose of my project is to discover the knowledge, attitudes and actions of parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME). My research question is, "What are parishioners' knowledge, attitudes and actions regarding ministry to the mentally ill?"

Overview

This project is designed to discover the knowledge, attitudes and actions of the parishioners of the AME Church in the Cleveland District of the AME Church. Mental health and mental health awareness have been under continuous analysis due to massacres in homes, churches, concerts, schools and other public places by individuals with mental health diagnosis. It has become more apparent each day that churches have not taken an active role in educating parishioners on mental health wellness or engaging the church community in adapting to the need for education on mental health issues. For the African American community, the church is the place where you can grow, develop, change, flourish and age. Church acceptance is critical in developing ministries to reintegrate members diagnosed with mental health conditions. The

function of the project is to measure the knowledge on mental illness, identify attitudes surrounding the disease and assess the actions taken and time commitment required in addressing change that creates an open and inviting church community for a former, faithful church member.

The specific focus of this project is discovering the knowledge, attitudes and actions of the parishioners of the AME Church in the Cleveland District of the AME Church on mental illness. The project will discover the resulting attitudes and actions of members when they are informed about mental illness within the church family. “Whosoever will let them come,” is the church’s battle cry, unless there is something that does not meet the defined appropriateness of the church. The churches that comprise the Cleveland District state that the churches are always open as a place of healing to all conditions of malady. This project will reveal attitudes about mental illness as well as reveal actions around mental health support ministries.

A survey assessment tool has been designed with questions to capture the knowledge, attitudes and actions of those who come in contact with persons who suffer from a mental health concern. Respondents to the survey are AME church members or clergy assigned to the Cleveland District. The survey tool uses a five point Likert scale with three sections: Section I is Demographics; Section II is Discovery which is subdivided into Knowledge, Attitudes and Actions; each with 16 questions; and Section III is Evaluation of the Study. At least 100 surveys will be emailed to the eighteen churches that make up the Cleveland District and provided at the Officer Leadership Training on February 3,

2018; plus, the Cleveland District Founder's Day Celebration on February 11, 2018.

Foundation

This project is significant to me because I have seen the many facets of mental illness acceptance and rejection. I have seen through the eyes of my family and church members the struggle of acceptance. I have seen rejection of the mentally ill by immediate family and church members; while at the same time, the rejection and shame was apparent in the eyes of my mentally-challenged brother. I have witnessed my brother struggle for acceptance from others while still battling complete acceptance of his own mental disorder. My brother was first diagnosed with depression, then with bi-polar disorder and now with paranoid schizophrenic. According to the Substance Abuse and Mental Health Services Administration, his mental health challenges are defined as:

> Depression is a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life. Bipolar disorder is a mood disorder that is also known as manic-depressive disorder. A person who is bipolar may experience deep depression with breaks of sanity and obsession as a complete mood shift. Schizophrenia is a serious brain disorder that distorts the way a person thinks, acts, expresses emotions, perceives reality, and relates to others. People with schizophrenia, the most chronic and disabling of the major mental illnesses, often have problems functioning in society, at work, at school, and in relationships. Schizophrenia can leave the person frightened and withdrawn. It is a life-long disease that cannot be cured but can be controlled with proper treatment. (SAMHSA 2015, Mental Disorders)

All three diagnoses were received within a two-year period with mental breaks preceding each one. With each break requiring a different treatment, the immediate family never accepted what was to be the "new normal." Each break never allowed the family or church family time to become familiar with that particular

diagnosis. Each break appeared to take more and more out of him with no recovery insight; what use to be normal was no more. Each break required more knowledge because there was so much that we needed to learn about mental illness. My brother and family experienced the same feelings of helplessness, uncertainty and confusion. Because of the lack of education on the disease and the initial shock of the diagnosis, it took at least four years to accept each diagnosis. With each mental break, there emerged a new person with a new medication and a new need.

During his illness, I learned what families endure to give of themselves. It takes commitment to help a person who does not believe anything is wrong and appears to enjoy living a life contrary to what is deemed acceptable. There was so much we did not know about the disease, and that lack of knowledge presented roadblocks that prevented the investment of time needed. The family wanted a quick fix because we were told medication should bring him back to what we each thought was “normal.” Patience was lacking from all and some family members were content with locking him up in the backroom, never to be seen in company again. It was better to find a place for him to live where he would be nurtured than to try to understand what was happening and re-adapt.

Each break also revealed my family’s attitude on mental illness. Some of the family distanced themselves from my brother and the disease as if it was contagious. Also, the reaction of the church family was a revelation to me. In the South, more specifically, middle Georgia, most small and medium size churches are family churches. That is also the makeup of the small and medium size churches in the Cleveland District. Therefore, when rejection of the mentally ill

occurs within the immediate family, there is a simultaneous rejection by the extended family within the church. We all wanted my brother to return to the time when life was great.

Working through the three mental breaks was a revelation about his past. He was fifty-five years old when he had the first mental break and by the time we were in the midst of the third, the doctors revealed to the family that this was not the first time; there is a history of mental illness. His wife of twenty-five years died suddenly and now the caregiver that he was accustomed to was no longer there to ensure he was taking his medication. At his request, the wife shielded his illness, which left his family to quickly figure out next steps in his recovery. Neither his biological family nor his church family understood that with medication he could lead a productive life. Today, my brother is retired on disability from NASA at Cape Canaveral and lives in Rockledge, Florida. I visit at least twice per year and he is living on his own and doing well with the help of support groups and medication. But, he is not open to returning to church.

What role should the church take in implementing change and acceptance when there are members whose lives take a dramatic change due to mental illness? Should the church's role go beyond tolerance and isolation? What does the bible have to say about mental wellness and community acceptance? How does the bible support those that now process their world differently and how is the community engaged? Does the bible support change and restoration or supports a system of separation and seclusion? I am going to engage various commentaries, traditional and non-traditional, on the biblical interpretation of my

scripture, Mark 5:1-20 (NIV). I am grounding my theology in “Black Liberation” theology. My historical reference is the role of the Black church as the primary caregiver and barometer for the Black race. If God knitted a plan for us in our mother’s womb before we were conceived and if God is our keeper, then why does the church fear God’s plan that may be perceived as different and not normal?

Biblical Foundation

The biblical foundation for my project is grounded in Mark 5:1-20 (NIV). This pericope is titled, “Jesus Restores a Demon-Possessed Man.” The traditional perspective, according to Pheme Perkins, states that this passage of scripture is about the exorcism of the gerasene demoniac, which is one of the first miracles attributed to Jesus (Perkins 1994, 581).” The story is about a man who was different and separated from his community, but because of Jesus’ selfless interventions, this man was restored and became a wonderful witness of the miracles and saving power of Jesus.

Perkins makes the following points concerning the beginning of Jesus’ ministry as Jesus teaches, heals and transforms lives.

- “Jesus is breaking down barriers that separate Jews from Gentiles; barriers that were separating the clean from the unclean (Perkins 1994, 582).” The ministry of Jesus included the miracles he performed in the life of the believers and the unbelievers. Jesus’ actions in community with others served as the calling card for the gathering of all people, including the Gentiles, so

that religious stereotypes were broken or destroyed. Jesus' mission was for all people to be made whole.

- "There is an unclean spirit present and impurities are piled one upon another. In the scripture, a man is living among the tombs, living among the dead and living among a large herd of swine (Perkins 1994, 583)." The struggles of life, the impurities of life that surround all individuals are not singularly focused or isolated and may affect a person's mental balance.
- "Social tensions can be enacted and resolved through exorcism rites. Exorcism of a demon within the man has been requested by the community, yet this is not the normal exorcism story (Perkins 1994, 585)." The community has served as witnesses to individuals who were once contributing members of society to now being witnesses to that same person deteriorating before their eyes because of a change that could only be explained as demon possessed. "There are signs of social and religious chaos. The demons have stripped the man of every shred of humanity (Perkins 1994, 583)."
- "The demon's name, Legion, implies a large number of people and contains a veiled reference to the devastation of people and property caused by the Roman occupation. God's kingly power has subdued imperial domination (Perkins 1994, 584)." The power of Jesus is greater than the destructive power of the demon and the damaging power of those in the community.
- "There is a violent sign of the demon's exit from the man; the demons escape into the swine, then into the sea and then drown themselves (Perkins 1994,

584).” The demons find they are no match for God and they flee into the swine but could not avoid God’s destructive power and are drowned.

- “The individual has been healed and people see the man who was once completely asocial is now in his right mind and wearing clothes (Perkins 1994, 584).” The man looks normal, he acts normal but he is not welcomed back into the community because society still sees him as the deranged man who lived in the tombs.

According to William L. Lane, the focus is on a violent man who lives in the tombs. Again, this author titles this passage as the Gerasene Demoniac: The Subduing of the Demonic. The following points have been made by the author:

> The function of demonic possession is to distort and destroy the image of God in man. The people of the town thought the man was insane and the man resisted their efforts to bind him with chains so they sent him to a place for poor people to wander in the tombs. People were afraid of the man; therefore, the actions of the people led to cruelty based on their misunderstanding. Jesus asks the name of the demon and received the name of “Legion” which implies multiple alien forces had taken possession of the volitional and active ego of the man. The man who had been possessed was seated, clothed and restored to wholeness of mind. The people were afraid and asked Jesus to leave them. As Jesus prepared to leave, the man begged Jesus to allow him to go with him. Jesus demonstrates his power over the demon and change happens. (Lane 1974, 180-189)

Many of the miracles and exorcisms of Jesus, along with the healings, involved breaking down traditional boundaries so that persons formally excluded from society are now included.

Ched Myers provides a nontraditional social-political perspective titled the “Second Inaugural Exorcism,” where Jesus takes action in his ministry of liberation (Myers 1988, 190-192). Myers makes the following points on how the

“Non-Traditional” perspective connects with the project in discovering the knowledge, attitude and actions of parishioners about the mentally ill. In the scripture you find the man who has a spirit residing in him and branding him as an outcast of society and living in a tomb, ostracized from community. Through the saving grace of Jesus, his life is changed because Jesus makes him whole.

> Jesus is confronted by a demon immediately upon his arrival. The demoniac’s dwelling among the tombs and the presence and role of the pigs symbolize impurity according to the Jewish cultural code. The King had to coerce the Jews to live there because the area was unclean; it was built on the site of a graveyard. The demon’s salutation to Jesus has Gentile overtones. Jesus is named “Son of the Most High God.” In the most dramatic exorcism in the Gospel, Jesus puts an end to the efforts by the demons to name him. Jesus obtains the name of the demon, “Legion” which has military ties referencing a division of Roman soldiers. (Myers 1988, 190-191)

Another non-traditional viewpoint is provided by Emerson B. Powery in the African American New Testament Commentary, from which I take my point of departure. The scripture section is titled, “Exorcism on the Gentile Side: The Crossing of Social Boundaries.” The commentary provides a view based on the African American experience and makes the following points:

> This is the first time Jesus, the Jew from Nazareth, enters Gentile country. Jesus begins his mission in Capernaum and his first act is an exorcism. The people fear the man and they also fear Jesus. Why are the people not pleased when they witness the new condition of the man? Jesus sends the man back to his people to tell others how much the Lord has done for him. Jesus becomes a person to fear as well as a person to respect. The demon has a mission of power but he is not stronger than God. Jesus presence results in a shift with the demon and the people. (Powery 2007, 130-131)

The demon leaves the man and the people are still fearful. The crossing of social boundaries takes us from socially unacceptable to acceptable with Jesus. The passage takes Jesus from a Jewish world into a Gentile world, letting all

know that Jesus comes for everyone, including the man in the tombs. The exorcism had the desired results, the man was restored and the demon realizes that Jesus is stronger. How do we aid all people in remaining active in their community when unknown adversity, such as a mental illness happens? Society tells us that we must remain where we are expected. If we move into the unacceptable realms of expectation; we allow ourselves to no longer see the person and the needs of the person, but we see the imprisoned person and what they have become. The focus of my project is demonstrated in the change of the Gerasene Demoniac moving from the position that crazy and insane people are not part of mainstream society and are not welcomed into the church but must be tolerated to a new position of wellness through restoration and wholeness.

All of the aforementioned nontraditional points are found in the discussion of the traditional perspectives. Both Perkins and Myers are breaking down the stereotypical barriers. The man is perceived as demoniac and feared but Myers and Powery opens the door to the “social psychology of mental illness,” and provides some clarity on how the mentally ill are viewed in relation to this scripture. Myers states, “Not denying that oppression can generate mental illness, a socio-literary interpretation reads the exorcism more broadly as a public symbolic action,” to satisfy the larger community (Myers 1988, 193). We need to blame something or someone to justify our actions and inactions. “True to Our Native Land,” which is more perceptive and relevant shows us how fear is a part of who we are. Powery states, “The troublesome quality of Black life in slavery was psychologically disturbing. This does not suggest a condition of neurosis but

that one's psychological well-being was continually challenged by the constant confrontations with the insanity of slavery" (Powery 2007, 130). As with mental illness, the constant evidence of change in behavior is insane to those affected. Mental illness is not easily accepted by the person who suffers with the disease or those who interact with the person and the resulting behavior is fear that is unfounded. We do not understand the behavior change in the person nor the overwhelming fear in us.

Theological Foundation

My project is grounded in Black liberation theology because those with mental health concerns in the Black community find themselves living life defined for them, because of a medical condition that society does not fully understand resulting in oppression for a select group of people. Cone quoted in Raboteau, expressed this idea about God's awareness of struggles within the Black race: "God identifies himself in human history with the struggle of Black people and has promised the ultimate liberation of the oppressed through the life, death and resurrection of Jesus" (Raboteau 1999, 120).

The Black community lives by what is written in the bible. We believe in God's word and place our trust in God who will guide us through all dangers. Floyd-Thomas et al states, "The biblical stories of principal interest for Black people are those that deal with oppression and liberation. The biblical characters, motifs, or touchstones speak directly to the experience of Blacks as an oppressed, marginalized and subjugated people" (Floyd-Thomas 2007, 56). In

the story of the Gerasene Demoniac, he is suffering, oppressed and thrown away; but lives anew with a focus on Jesus because of Jesus' miraculous power to heal.

Black liberation theology includes the black experience. From slavery, back to Africa movement, to share cropping, to the Emancipation Proclamation, to the right to vote, to Jim Crow, to separate but equal, to forced integration, to "Say It Loud I'm Black and I am Proud," to Affirmative Action, to Black Lives Matter, God has been there as the sustainer and protector. Floyd-Thomas et al states,

> "Black Liberation theology is defined as the assertion of the importance on conjoining religious practice and faith with political activism and social change for the betterment of the Black community. The primary affirmations include God as revealed in scripture and in Jesus Christ, the Oppressed One, who works primarily for the liberation of oppressed people. In the process, God takes on the identity of those on whose behalf he is bringing about liberation." (Floyd-Thomas 2007, 248)

God and spirituality serves as the glue that held the Black race together. The spiritual connection within the Black community of faith provides the Black race the will power to continue on and not stop. According to Diana Hayes, in Forged in the Fiery Furnace, "African American spirituality is a result of the encounter of a particular people with their God. It is their response to God's action in their history in ways that revealed to them the meaning of God and that provided them with an understanding of themselves as beings created by God. Spirituality is a direct result of God in our life and aids in defining our definition of theology" (Hayes 2012, 2). From the Old Testament in Joshua which says to the people, "Be strong and courageous. Do not be afraid; do not be discouraged, for

the LORD your God will be with you wherever you go" (Joshua 1:9 NIV); to the New Testament where Jesus heals the demoniac, "Jesus did not let the impure spirit speak, but said, "Go home to your own people and tell them how much the Lord has done for you, and how he has had mercy on you" (Mark 5:19 NIV), God is our sustainer.

Jesus was preforming miracles and the exorcism of this man resulted in a miraculous restoration. This exorcism was not normal for the present day and time which leads to the question of "What is normal today for those who suffer with a mental health challenge?" In dealing with life and all the trials and blessings that life brings, normal takes on different meanings depending upon our environment, our attitude, our actions and the circumstance in which we find ourselves. This man who had been left alone because of the community's fear of the unknown concerning his present behavior now needs to find a "new normal." This change becomes difficult for the man to do by himself; divine intervention is his only hope. God is there to make a "new way."

The mentally challenged find themselves in situations similar to the man in the tombs. They are part of the faith community and are dependent upon a God who they believe in. They are surrounded by a community of believers who all believe in this same God. Yet, the communities exclude this group of people and label them mentally ill. This ensuing battle to wholeness, that does include God, can be likened to being bound by chains resulting in a "separate but equal prison." Further, it can best be described as another page in the many struggles that God has already brought the Black race through. Just like the demoniac, the

Black race suffered in silence, cried out when they were alone and placed all their hope and faith in God; they were waiting on Jesus to direct a positive outcome on their behalf. God healed and partially restored the Gerasene Demoniac who became a witness for Jesus. For those who suffer with mental health concerns, healing is a long process, but the God of the oppressed will never leave them nor forsake them.

Historical Foundation

My project is grounded in the historical role of the Black church as the primary caregiver and the barometer for the Black race. Neighbors states, "African Americans are a highly religious people. Data from the National Survey of Black Americans (NSBA) show that 68% of adult Blacks belong to a church and that 92% of members attend church" (Neighbors 1999, African American Minister as a Source of Help). Historically, the Black church served as the catalyst and change agent for the Black community. The church was the gathering place where the community came together, evaluated life adversities, formulated plans and grew stronger through the struggle to survive and move forward. Black churches, like the African Methodist Episcopal Church, was founded through mutual aid and social justice for the Black race. Day states, "Because Black churches provided a way for Black persons to reclaim their human dignity, identity and worth in light of the time, Peter Paris named the early Black church the "surrogate world" for the Black community" (Day 2012, 23). The Black church took care of its own; no matter the circumstances.

From Africa, to slavery, to Jim Crow to the Civil Rights Movement to our present time, the Black community has been victorious and has always looked to the Black Church to provide guidance through tumultuous and changing times. Paris states, “The Black church is in some sense a “universal church,” claiming and representing all Blacks out of a long tradition that looks back to the time when there was only the Black church to bear witness to “who” or “what” a person was and how that person survived as they stood at the base of the community” (Paris 1985, 8).

Felder states, “In its broadest application, the Black religious experience extends well beyond the parameters of the African American religious experience and the Bible. There is an astonishing diversity of religious beliefs and practices in the history of the world’s Black people” (Felder 1989, 5). Before the moral dilemma of mental illness, the Black church focused on racism. The realities of racism created a shared struggle created a shared struggle and a consensus on what was needed to move the race forward and be all inclusive. The Black community is in relative agreement on racism being a significant issue; but is not as clear on the moral questions of mental illness, abortion and sexuality. The ethical conflict concerning mental illness has gotten lost due to fear of the unknown and the lack of knowledge excludes mental illness from the battles that we fight in the Black community.

Day states, “Black churches have been important historical frameworks wherein Black people could experience economic relief and cultural flourishing. The Black church has a long history of providing hope and cultural freedom for

poor members within their own communities" (Day 2012, 3). Encountering the Bible in the life of the African American race is descriptive of "freedom road," where the word of God is the way out of bondage and the word of God has become the "living hope." The Bible contains that "sustaining momentum" that gives the Black race strength, no matter the struggle, to work toward the purpose of obtaining freedom. Page states, "In the face of the dehumanizing and humiliating condition of slavery, African descendants searched the Bible, and when they encountered the Bible, they searched for the vestiges of freedom, home, justice and an alternative future" (James 2010, 11)

Like the Gerasene demoniac, mentally ill individuals are imprisoned and separated from society. The Gerasene demoniac, that is found in Mark 5:1-20, is a man with an impure spirit and this man lived in the tombs. And, since no one could bind him or understand him; his community ceased to thrive. Inaccessible and out of the way would be how one would describe the demoniac in his new home. His life would be reminiscent of the life of one who grew up with limited knowledge of the world outside of the tombs. Paris states, "Whenever persons are rejected by society, the result is a loss of place; the result is exile. Whenever a pattern of rejection persists from one generation to another and is firmly rooted in an ideology, the rejected ones become destined to a veritable permanent state of exile wherein they have no sense of belonging, neither to the community nor to the territory" (Paris 1985, 59). The churches role is critical and is often the catalyst to community acceptance which leads to changes in perception in how a person with mental health challenges are received. Acceptance and open

discussion often takes the power out of the fear of the unknown. The church has always been the place where all are welcomed. Day states, “Black religious and sociological scholars have described the Black Church as an institution, a human community of persons that possesses a religious worldview and orientation that structure its relational ties, filial bonds and sets of practices” (Day 2012, 16).

Context

The context of my project is the Cleveland District of the African Methodist Episcopal Church (AMEC); a church organized out of desire for religious freedom. Dickerson says,

> The African Methodist Episcopal Church (AMEC) was organized in 1794 in Philadelphia, PA, with Bethel AMEC as the first church where Richard Allen served as Pastor and was ordained as the first Bishop. The word African means that people of African descent and heritage organized the church. The AMEC grew out of the Free African Society which was a mutual aid society organized by Richard Allen, Absalom Jones, and others established in Philadelphia in 1787. When officials at St. George’s Methodist Episcopal Church pulled blacks off their knees while praying, Free African Society members discovered just how far American Methodists would go to enforce racial discrimination against African Americans. (Dickerson 2017, Our Church)

The North Ohio Conference of the AMEC is in the Third Episcopal District which is comprised of Ohio, West Virginia, and the Western half of Pennsylvania. The North Ohio Conference is in the northern half of Ohio and is comprised of two conferences: the Youngstown District and the Cleveland District. The Cleveland District is headed by a Presiding Elder that oversees 19 churches that is comprised of 3,905 members. The majority of the 19 churches are in

Cleveland, with churches located in Mansfield, Toledo, Lima, Elyria, Lorain, Crestline, and Sandusky, Ohio.

> Even though the AMEC church was birth out of adversity and has a mission to minister to the social, spiritual, and physical development of all people as a church we still fall short in educating and supporting members with mental health challenges. In the post-civil rights era theologians James H. Cone, Cecil W. Cone, and Jacqueline Grant who came out of the AME tradition critiqued Euro-centric Christianity and African American churches for their shortcomings in fully impacting the plight of those oppressed by racism, sexism, and economic disadvantage. (Dickerson 2017, Our Church)

I am a cradle AME, meaning I was born into the AME church, where my family still worships. I accepted my call into ministry in 1999 at St. Paul AME church in the Cleveland District and I have pastored for seven years at Greater Mitchell Chapel, which is also located in the Cleveland District in Mansfield, Ohio. In my years as pastor, associate pastor and youth pastor, I have seen many members with mental health challenges, resulting in suicide attempts, broken families and indescribable hurt; this was mainly due to lack of knowledge.

Project Goals

1. To evaluate the secondary literature on the subject matter.
2. To discover the knowledge of parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME).
3. To discover the attitudes of the parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME).
4. To discover the actions of the parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME).

5. To evaluate the study.

Design, Procedure and Assessment

1. Collect primary and secondary material on various forms of mental illness, mental health and mental wellness.

2. Create a survey for distribution to discover the knowledge, attitudes and actions of parishioners about ministering to the mentally ill in the Cleveland District of the North Ohio Annual Conference located in the Third Episcopal District of the African Methodist Episcopal Church (AME).

3. Distribute and collect the survey; as well as, use an online survey application to analyze the data.

4. Analyze and evaluate material.

5. Document the findings.

6. Evaluate the study.

Assessment strategy will consist of the participants completing the survey that evaluates the study.

Personal Goals

- To obtain a better understanding of the various ways God intervenes in the life of those who suffer with mental illness.

- To obtain a better understanding of the various ways God uses spiritual restoration for people that are sick.

- To continue to educate myself and the church on how God's instructions defines our actions in adjusting to change.

- To work harder to preserve my own health so I can be a better pastor.

Calendar

1.	Proposal …….	January 2018
2.	Collect material ……..	December – January 2018
3.	Analysis …….	January – February 2018
4.	First draft ……	February 2018
5.	Second draft …….....	February – March 2018
6.	Oral Defense ……..	March 2018
7.	Graduation …….	May 2018

Core Team

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Director of Doctor of Ministry in Black Church Studies, Ashland Theological Seminary
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Vice President and COO, McCreary Center for African American Religious Studies

Support Team

Julius and Brandon Jackson, children
Rev. Gwendolyn Johnson, Women in Ministry
Rev. Debra Austin, Women in Ministry

Evangelist Dr. Lucille Davis, sister
Robert L. Wright, brother
Rev. Otis Gordon, DMIN Dean of Board of Examiners Cleveland District

Life Management Plan

My goal is to finish my project and continue to help my brother to reengage society without being hesitant to admit that he can no longer do all the things that came so easily for him. My project will require extensive time in reading literature on mental health and evaluating mental health issues, as well as understanding the various approaches such as: the use of group sessions, therapy and medication. I will also evaluate how the illness changes not only the life of the person but the life of those who become care givers and the life of people that they may encounter. I fear for his life because of the mental illness and the way that the world reacts to those who have been diagnosed with mental health issues. I will continue to pray for his safety and for acceptance within the church. In addition, I will pray for his interacting with people outside of our community, especially the police. The police are a huge concern when the tendency is to shoot first, then try to obtain information and finally to assist the person later.

Time management will be a crucial factor. I am working a very demanding full time secular job, pastoring full-time at Greater Mitchell Chapel A.M.E. and working on completing my degree. In developing my dissertation, I will incorporate the work from my doctoral studies and in my free time I will continue to read information on mental health and the church involvement with mental

health support. I will work diligently to not accept any more major projects from the conference, district and connectional church as the time commitment to the church's other duties can also result in being full time commitments. I will also schedule other associate ministers more opportunities to preach. I will limit travel, speaking engagements and other duties that will consume large amounts of time. This journey has been great because the Lord has been and will continue to be my companion in all things. I will continue to pray, meditate and lean on the Lord as I complete this journey of my education.

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APPENDIX TWO

ASSESSMENT TOOL

Mental Illness Ministry Survey

SECTION I: DEMOGRAPHICS

Gender: _____ Male _____ Female

Section II: DISCOVERY

1. Knowledge

1. I know that clinicians categorize depression as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

2. I know that clinicians categorize hoarding as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

3. I know that clinicians categorize overeating as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

4. I know that clinicians categorize alcoholism as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

5. I know that clinicians categorize drug addiction as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

6. I know that clinicians categorize attention deficit hyperactivity as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

7. I know that clinicians categorize sexual addiction as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

8. I know that clinicians categorize social isolation as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

9. I know that clinicians categorize continuous anxiety as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

10. I know that clinicians have developed treatments for mental health disorders that allows the person to function in society?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

11. I know that clinicians have concluded a shorter life expectancy for persons diagnosed with a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

12. I know that mental health professionals have established services that will aid a person with a mental health crisis?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

13. I know that my church provides contact information on various health organizations that provide mental health services?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

14. I know that physicians categorize mental health as a vital part of overall wellness?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

15. I know that clinicians categorize some mental health conditions as hereditary?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

16. I know that clinicians categorize persons showing signs of chronic homelessness by moving frequently are showing mental imbalance tendencies?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

2. Attitudes

1. I believe that clinicians categorize depression as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

2. I believe that clinicians categorize hoarding as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

3. I believe that clinicians categorize overeating as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

4. I believe that clinicians categorize alcoholism as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

5. I believe that clinicians categorize drug addiction as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

6. I believe that clinicians categorize attention deficit hyperactivity as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

7. I believe that clinicians categorize sexual addiction as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

8. I believe that clinicians categorize social isolation as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

9. I believe that clinicians categorize continuous anxiety as a mental health disorder?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

10. I believe that clinicians have developed treatments for mental health disorders that allow the person to function in society?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

11. I believe that clinicians concluded a shorter life expectancy for a person diagnosed with mental health disorders?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

12. I believe that mental health professionals have established services that will aid a person with a mental health crisis?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

13. I believe that your church provides contact information on various health organizations that provide mental health services?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

14. I believe that physicians categorize mental health as a vital part of overall wellness?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

15. I believe that clinicians categorize some mental health conditions as hereditary?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

16. I believe that clinicians categorize persons showing signs of chronic homelessness by moving frequently are showing signs of mental imbalance?

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

3. Actions

1. I am willing to participate in ministries that help people who are depressed.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

2. I am willing to participate in ministries that help people who hoard.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

3. I am willing to participate in ministries that help people who over eat.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

4. I am willing to participate in ministries that help people who are alcoholics.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

5. I am willing to participate in ministries that help people who have drug addictions.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

6. I am willing to participate in ministries that help people who have attention deficit hyperactivity.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

7. I am willing to participate in ministries that help people who have sexual addictions.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

8. I am willing to participate in ministries that help people who engage in social isolation.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

9. I am willing to participate in ministries that help people who experience continuous anxiety.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

10. I am willing to participate in ministries that help people with mental health disorders function in society.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

11. I am willing to participate in ministries that help people diagnosed with mental health disorders.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

12. I am willing to engage in ministries that will aid a person with a mental health crisis.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

13. I am willing to engage in ministries that help churches provide contact information on organizations that provide mental health services.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

14. I am willing to engage in ministries that help people with their overall mental health.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

15. I am willing to work with others in developing church ministries to provide written educational material on mental health.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

16. I am willing to work with others in developing partnerships with homeless support groups for persons showing signs of chronic homelessness.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

Is there anything further about various actions not mentioned above that you want to add?

SECTION III: EVALUATION OF THE STUDY

1. This study is helpful to me.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

2. This study allowed me to express my feelings about how churches minister to those with mental health challenges.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

3. This study increased my understanding of mental illness.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

4. This study should be made available to all churches seeking to establish mental wellness ministries.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

5. This study enlightened me about the importance of mental wellness ministries in churches.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
5	4	3	2	1

THANK YOU FOR YOUR PARTICIPATION.

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