Journal of Psychology and Christianity
2021, Vol. 40, No. 1, 50-60

ISSN 0733-4273

Why Church Attendance is Difficult for Children with Common Mental Health Conditions and Their Families

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Children and adolescents with mental health conditions are less likely to attend religious services than unaffected youth. Depression is associated with a 73% reduction in the likelihood of attending a worship service, while the presence of disruptive behavior disorders, anxiety disorders, or attention-deficit/hyperactivity disorder are associated with 55%, 45% and 19% reductions, respectively. In this paper, we hypothesize lower rates of church attendance result from functional limitations associated with mental health conditions that make entry into a church difficult. Children and youth with mental disorders experience more difficulty meeting common expectations for social interaction and self-control in worship services, small groups, Christian education, service activities, and other church functions. Given the heritability of these conditions, their parents often experience similar challenges engaging in ministry activities. We propose a mental health inclusion model for use in churches of all sizes and denominations. The model facilitates recognition of common barriers to church engagement and assimilation and application of inclusion strategies across ministry activities and environments offered to all.
Keywords: mental health, church, inclusion, children, families

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Little data are available examining the impact of mental illness upon church attendance, despite mental illness representing the most common cause of disability worldwide among youth ages 10-24 (Gore et al., 2011). The preponderance of research on mental health and religion examines religion and religious participation as a psychological and social resource for coping with stress (Koenig, 2009).

Religiosity has been associated with reduced risk of depression and is robustly associated with more rapid remission of depression in patients with serious mental illness and reduced risk of suicide (Koenig et al., 2012; Koenig, 2007). In a study of over 100,000 U.S. healthcare professionals, attendance at religious services at least once per week was associated with a 68% lower hazard of death from despair (i.e., alcohol, drugs, suicide) among women and a 33% lower hazard among men compared with participants who never attend (Chen et al., 2020).

There is similar outcome data for anxiety disorders. Religious interventions decreased symptoms more rapidly than secular interventions in randomized studies of participants with anxiety disorders (Koenig et al., 2012).

The presumption throughout the literature is that participation in worship services and other religious activities promotes positive mental health outcomes. An alternative hypothesis is that persons with more severe manifestations of mental illness experience greater difficulty participating in church or other religious activities. The ability to engage in church activities self-selects individuals with less functional impairment from their mental health conditions.

A random sample of 1,714 adults were interviewed about health and religiosity in the third wave of the Baylor Religion Survey (Dougherty et al., 2011). Worriers—people who self-identified as feeling worried, tense, or anxious for ten days or more in the preceding month (17% of the U.S. population)—were less likely to have attended a religious service in the past year (67% vs. 75%), attend religious services on a weekly basis (17% vs. 37%), read the Bible on a weekly basis (13% vs. 29%), or

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consider themselves religious (19% vs. 39%) compared to non-worriers. Adults who experienced sadness or depression for ten or more days (11% of participants) during the preceding month were less likely to have attended a religious service in the past year (61% vs. 78%), attend services weekly (15% vs. 36%), read the Bible weekly (13% vs. 28%), describe themselves as "very religious" (20% vs. 37%) and more likely to identify as religiously non-affiliated (23% vs. 10%) compared to participants free of depressive symptoms.

Whitehead (2018) examined the impact of physical, mental health, and developmental disabilities upon church attendance using data generated from nearly 100,000 phone interviews conducted in each of three waves (2003, 2007, 2010-2011) of the National Survey of Children's Health (NSCH). Families of children with no chronic health condition were less likely to report never attending church services compared to the overall sample. The percent increase in odds of children with chronic health conditions never attending church was 84.1% for children with autism spectrum disorders, 72.7% for children with depression, 54.6% for children with oppositional defiant disorder or conduct disorder, 44.7% for children with anxiety disorders, and 19.3% for children with attention-deficit/hyperactivity disorder (ADHD). Conditions not impacting church attendance included asthma, diabetes, Tourette Syndrome, epilepsy, hearing or vision problems, intellectual disabilities, and cerebral palsy.

According to the U.S. Centers for Disease Control (2020), 9.4% of children aged 2-17 years (approximately 6.1 million) have received an ADHD diagnosis, 7.4% of children aged 3-17 years (approximately 4.5 million) have a diagnosed behavior problem, 7.1% of children aged 3-17 years (approximately 4.4 million) have a diagnosed anxiety disorder, and 3.2% of children aged 3-17 years (approximately 1.9 million) have a depression diagnosis. Comorbidity is common, in that children with ADHD display elevated rates of depression, nearly three in four children with depression also have anxiety, and almost one in two children with ADHD also have behavior problems. For children with anxiety, over one in three also have behavior problems and approximately one in three also have depression.

These data suggest that an inclusion strategy for families of children with common mental health conditions is needed. ADHD is five times more common than autism and eight times more common than intellectual disabilities (Zablotsky et al., 2019). Given the prevalence of anxiety, depression, and disruptive behavior disorders, mental illness is the most common disability impacting church attendance and engagement in children and youth.

Multiple factors contribute to the absence of programs and strategies for inclusion of children, adults, and families impacted by mental illness. One is the "hidden" nature of many mental health conditions. Children and adults with these conditions who come to church often seek to avoid calling attention to themselves and reject any special treatment or supports that might single them out as "different." Stigma regarding mental illness prevalent in multiple strains of American Christianity causes many to keep their struggles to themselves (Peteet, 2019). Mental health-related disability may be reflected in some, but not all, day-to-day activities. A person with a mental health condition associated with sensory processing differences may have no difficulty sitting through a Bible study or sermon but experience profound distress in a worship service with especially loud music.

Impacts of Church Culture on Attendance and Engagement

We now present a model for mental health inclusion in churches, grounded in a recognition of how functional limitations associated with mental health conditions often clash with "church culture"—defined here as expectations for how attendees will act and respond when gathered for worship, Christian education, missional service, social activities, and other functions of the local church.

Carter (2007) developed a framework for conceptualizing impediments to church attendance and engagement for individuals with intellectual or developmental disabilities, categorizing barriers as architectural, attitudinal, communication, programmatic, or liturgical. His framework offers a useful starting point for considering the barriers to church attendance for all with mental health disorders.

This framework has worked well for guiding inclusion strategies for children and adults with physical disabilities. Thousands of churches have taken steps to make their facilities more accessible—providing elevators, restrooms, wheelchair

ramps, amplification equipment, or interpreters for persons with hearing impairments. Some churches provide nurses to assist attendees with significant medical needs. Excellent ministries have emerged for serving children and adults with "special needs" offering a modified Christian education curriculum, "buddies" for children or teens who require individualized attention, and special events, such as respite events for parents or proms as outreach to adults in assisted living facilities.

Established models of disability ministry designed to serve children with physical, intellectual, and developmental disabilities are not working for those with common mental health conditions. Disability ministry in the late 20th and early 21st centuries has largely served persons who unequivocally bear no personal responsibility for their conditions, exemplified by the man with congenital blindness miraculously healed by Jesus in John 9. Church leaders recognize the diminished capacity for moral agency among children and adults with more profound intellectual or developmental disabilities. Mental illness forces us to consider the individual's ability to make moral judgments grounded in biblical teaching and their capacity to refrain from actions and behaviors identified as sinful in Scripture. The extent to which mental illness mitigates a child's ability to control their own behavior or reflects upon the quality of parenting they receive is far more ambiguous.

Several hypotheses have been proposed for why children and adults with mental illness have been poorly served by existing disability ministry models.

- The term "mental illness" is used to describe a very broad range of conditions affecting cognition, perception, mood, emotions, and behavior. The support needs of a child with social anxiety are radically different than those associated with oppositional defiant disorder or a teen with early-onset schizophrenia. Recognition of these distinctions within the church is rare.
- Mental health disabilities can be difficult to recognize. Symptoms are often episodic. A child or adult with a mood disorder may function well for months or years until signs of depression or mania emerge. Families are often reluctant to disclose a child's mental health condition to church staff and volunteers. Many adolescents will avoid any ministry or support that draws attention to their differences.
- Mental illness is stigmatized in many churches in ways other disabilities are not.
- Functional impairment from mental illness is often situation specific. The aspiring valedictorian may be overwhelmed by the social demands of youth group, or the star quarterback may be unable to sit through a chapel service because of vulnerability to panic attacks inside crowded or confined spaces.

Grcevich (2018) introduced a framework for church-based mental health inclusion building upon the established practice in disability ministry of identifying impediments to church attendance and engagement, taking into account the heterogeneity of functional impairment associated with common mental health conditions; the extent to which impairment is present some of, but not all, the time in some, but not all, situations; and the reluctance of affected individuals to self-identify to pastors, church staff, and volunteers. It identifies seven barriers to church attendance for children and adults with mental health conditions and their families: stigma, anxiety, executive functioning, social communication, sensory processing, social isolation, and past experiences of church, along with a set of inclusion strategies for overcoming existing barriers sufficiently flexible for use in churches of all sizes and denominational traditions.

Stigma

LifeWay Research (2013) conducted a telephone study of 1,001 U.S. adults in which 55% of non-churchgoers *disagreed* with the statement: "If I had a mental health issue, I believe most churches would welcome me." One explanation may be outsiders suspect the presence of ongoing mental illness will be interpreted by churchgoers as evidence of a lack of faith or diligence in religious practice. Evangelicals or fundamentalists were more likely than other Americans (48% vs. 27%) to endorse the statement that people with serious mental illnesses like depression, bipolar disorder, and schizophrenia can overcome their conditions through Bible study and prayer alone.

Historically, churches have been on the forefront of caring for persons with conditions now understood as mental illness. The church became increasingly disconnected from mental health care throughout the twentieth century as influential theories arose to conceptualize and guide treatment grounded in principles in conflict with

traditional church teachings.

Freud's theoretical framework for psychoanalysis viewed guilt as pathological and rejected the concept of guilt as a warning from the conscience of the need to recognize and deal with sin. The psychodynamic psychotherapies derived from Freud's work attribute behavior to instinctive urges or drives—a stark contrast to centuries of Christian teaching that views human behavior as actions resulting from humankind's exercise of their God-given freedom to choose right from wrong, for which the individual bears personal responsibility.

Two foundational assumptions of behaviorism are that nature is the only reality and reality can only be measured through our senses. From a Christian perspective, behaviorism is fatally flawed because its practitioners neglect to consider spiritual dimensions of human existence that cannot be readily quantified and measured. Pure behaviorism is antithetical to the construct of free will and biblical teaching on the importance of the soul.

Humanistic therapies emerged in the mid-20th century in response to the determinism inherent in psychoanalytic and behavioral theory. Self-fulfillment and self-actualization are the goals of humanistic treatment conducted under the assumption the individual is responsible for their own happiness and accountable to only themselves. Adherents of humanism struggle to acknowledge there is a God to whom individuals are accountable. The emphasis on subjective experience and rejection of moral absolutes is incompatible with two thousand years of Christian teaching.

Powlison (1996) detailed how the growing cultural influence of secular therapies triggered an anti-psychiatry movement among conservative Protestants. Many influential pastors and church leaders concluded it was impossible for Christians to be helped by therapies grounded in understandings of humanity incompatible with biblical truths. Psychotherapy constituted a threat to the faith of believers. Nouthetic counseling emerged as an alternative treatment approach grounded in the ideas that everything necessary to counsel people for emotional or behavioral problems that are not unequivocally organic can be found in Scripture; the Bible is sufficient for counseling; the underlying cause of mental illness is sin; and mental health practitioners dissuade people from taking responsibility for their emotions and behavior (Adams, 1986). Criticism of secular approaches to mental health led to criticism of individual Christians seeking secular mental health services. Highly respected church leaders within the reformed and evangelical traditions continue to express suspicion of medical and psychological approaches to mental health diagnosis and treatment.

John Piper (2009) described five-year-olds with self-control difficulties as "unregenerate" and attributed their behavior to parents who fail to "restrain the egocentric impulses of their children and confirm in them every impulse toward courtesy and kindness and respect." John MacArthur (1996) described parents who give permission for their children to take medicine for issues with self-control as doing so "when they will not do it God's way" and implied that parents who do so are choosing to turn their children into "drug addicts." Such attitudes help to explain the perception among many parents that "people in the church think they can tell when a disability ends and bad parenting begins," (Grcevich, 2018, p. 151).

Anxiety

Children and adults with an identified anxiety disorder experience excessive and persistent anxiety or fear inappropriate for their level of maturity that significantly interferes with tasks of daily living, including participation at church. Anxiety disorders represent the most common mental health condition in adolescents and adults and the second most common condition in children (National Institute of Mental Health, 2017).

While many factors contribute to the development of anxiety disorders, a key finding from neuroimaging studies is a relationship between abnormal limbic system activity (the brain area responsible for modulating emotions) and a propensity for overestimating risk in new or unfamiliar situations. Abnormal connections between the limbic system and prefrontal cortex (an area of the brain responsible for higher order thinking and self-control) have been associated with anxiety disorders in children (Blackford & Pine, 2012).

Anxiety represents a significant barrier to church attendance for children in large part because it represents a barrier to church attendance for their parents or caregivers. A parental history of anxiety (especially maternal history) contributes to a twofold to sevenfold increase in the risk for anxiety in their offspring (Low et al., 2012). Consider the range of challenges adults and children

with anxiety disorders may experience in visiting or assimilating into a new church.

. They may fear being dressed differently than everyone else or becoming the center of attention.
. A child may worry they will not know or recognize anyone else in their Sunday school class.
. A parent may presume the adults they encounter on an initial visit—greeters, the children's or student ministry director, their child's Sunday school teacher, ushers, other worshipers, the pastor in a smaller church—are harshly scrutinizing them.
. A child with separation anxiety may become demonstrably emotional at a church where parents are discouraged from bringing children into the adult worship service.
. An adult might experience great discomfort from expectations for self-disclosure in the presence of relative strangers in churches where small group participation is encouraged.
. A child or adult with obsessive-compulsive disorder (OCD) may go to great lengths to avoid physical contact with other worshipers, objects, or furniture because of contamination fears. Sermons or Sunday school teaching may trigger obsessive fears of losing their salvation.
. A child or adult with agoraphobia may avoid church if they are not assured of seating near an exit at worship services where they can leave without drawing undue attention to themselves.
. A teen or adult may be less likely to register for church activities if a phone call to an unfamiliar person is a necessary step in the registration process.
. A child or teen with separation anxiety may feel overwhelmed by the prospect of participating in overnight retreats and mission trips.
. A child or adult with performance anxiety may avoid joining a church if a public profession of faith or baptism is required.
. A parent of a child with anxiety may never return to church if arbitrary rules or decisions cause their child to be separated from someone they depend on for companionship—if they cannot attend Sunday school with a family member or friend in a different grade or age group.

A useful exercise for pastors and ministry leaders is to consider how they would redesign their church's worship services, Christian education, outreach, and fellowship activities if 100% of their attendees experience one or more anxiety disorders.

Executive Functioning

Executive functioning refers to the cognitive abilities involved in modulating other abilities and behaviors. Executive functions represent the means through which children and adults acquire language, make plans, establish priorities, manage time, delay gratification, and exercise conscious control over thoughts, words, and actions.

Executive functioning difficulties are a core feature of ADHD and very common among persons with autism spectrum disorders (Barkley, 1997). Executive functioning is often compromised in children and youth with mood disorders, anxiety disorders, and fetal exposure to alcohol, drugs, and other toxins. Additionally, executive functioning is adversely affected by stress hormones and neural pathways activated in response to adverse childhood experiences, including trauma and abuse (Fisher et al., 2011). This capacity is often greatly compromised in children, teens, and adults with intellectual or developmental disabilities and represents an area of overlap between mental health ministry and special needs ministry.

Scripture places a high value on self-control. The capacity to control one's words and actions are evidence of God's work within us and a key marker of spiritual maturity.

Hathaway and Barkley (2003) hypothesized that persons with ADHD face greater difficulties in religious socialization, religious focus, internalization and integration of faith, stability of spiritual growth, and religious alienation. Their capacity for self-control is often highly dependent on their level of interest in the task at hand and characteristics of the environments in which they find themselves.

Common challenges to church participation among children and youth with executive functioning weaknesses include the following:

. The process of preparing a child with severe executive functioning deficits for and transporting them to church may leave parents or caregivers exhausted.
. Parents choose to not bring their child to church out of concern for their inability to keep impulsive or aggressive behavior in check.
. They may experience more difficulty sitting, standing, or kneeling for an extended time during worship services designed for adults, especially when they become bored.
. They may experience embarrassment or frustration if expected to memorize Scripture or

prayers.

. Some parents are instructed to avoid use of prescription medication on weekends essential to their child's ability to maintain focus and impulse control.
. Excessive stimulation from children's or student ministry worship activities may negatively impact the ability of some youth to maintain self-control.

All too often the very people who should be turning to the church for help experience embarrassment and shame. The inadequacy of the church's understanding of mental illness is demonstrated by each failure to respond compassionately when children and adults struggle to fulfill expectations for self-discipline and emotional control.

Sensory Processing

Sensory processing disorder (SPD) is not currently recognized as a stand-alone medical condition, but sensory processing difficulties are frequently associated with common mental health conditions. The link between sensory processing and mental illness is sufficiently strong to merit inclusion in the National Institute of Mental Health's (NIMH) Research Domain Criteria (RDoC) framework for identifying the root causes of mental illness (Harrison et al., 2019; NIMH, 2019). Five percent or more of children and teens in the United States experience significant functional impairment because of abnormal sensory processing (Ahn et al., 2004).

Persons with sensory processing differences often become overwhelmed because of difficulty integrating too much or too little incoming information from their senses—sight, smell, touch, hearing, and taste. Children and teens with *hypersensitivity* often have marked aversion to noise, light, touch, and taste. They may be extremely picky about the feel of clothes against their skin, pull away from others in response to touch, experience pain in the presence of loud noise, or become nauseous around persons wearing strong fragrances. They may be accident-prone and often avoid gross motor activities involving strength, balance, or coordination. Youth with hyposensitivity are often sensory seekers. They love tight hugs, physical contact, amusement park rides, trampolines, climbing, jumping, and splashing. They may also have a hard time sitting still and keeping their hands to themselves at a worship service or church activity. Some may experience hypersensitivity and hyposensitivity simultaneously.

Families of children and youth with sensory processing differences face multiple potential pitfalls when attending a worship service. Areas near entrances and exits are often crowded. Ambient noise levels and multiple conversations taking place at once produce distress. Physical proximity often results in lots of bumping and touching. Children with an exaggerated "fight or flight" response may attempt to run away or experience severe emotional outbursts.

Worship services frequently produce sensory overload. While high-energy worship experiences with loud music and bright lights may be engaging for persons with sensory hyposensitivity and capture the attention of children and adults otherwise preoccupied with electronic devices, persons with high sensitivity to sensory stimulation often avoid this type of service. Extended periods of standing or kneeling in some Christian traditions may result in excessive discomfort. Handshakes or hugs are unpleasant, as is physical contact during prayer. Seating is often experienced as uncomfortable. Expectations for appropriate dress may preclude some children from attending church who insist upon wearing athletic wear or soft, casual clothing. Children or adults with sensory processing differences may struggle to tolerate the scent of perfume or cologne worn by multiple worshipers seated nearby.

Special church events often produce unique sensory challenges. Church festivals and Vacation Bible School experiences often combine high levels of physical activity and sensory stimulation. Children and adults with hypersensitivity may avoid weekend retreats at outdoor campsites and mission trips where the comforts of home are not readily available.

Social Communication

Social communication deficits are common among persons with a broad range of mental health and developmental disabilities. In addition to representing one of the two defining features of autism spectrum disorders in the DSM-5, social communication is often a major source of functional impairment among children and adults with psychotic disorders, ADHD, anxiety disorders, and pragmatic language disorders (American Psychiatric Association, 2013).

Desire for community is reported in a Gallup survey to be one of the top reasons given for attend-

ing church (Newport, 2007). Studies have identified friendliness of members and fellowship as key reasons for choosing a church and maintaining a high level of involvement at church (Rainer, 2008). Children and adults who struggle with social communication often desire authentic friendships in which they can be known, understood, and valued. They want to belong to a larger community where they can be recognized for their gifts and talents. Many desperately want to belong to a church.

An adult or child who struggles to make or keep friends is less likely to know someone who would invite them to church. Attending a worship service as a passive observer comes with the prospect of multiple social interactions and potential for embarrassment. One of the most powerful turnoffs to attending church for middle or high school students with social skill deficits is the experience of encountering peers who have bullied them at school or through social media.

Participation in Bible studies or small groups where deeper connections are formed is difficult for someone who does not follow social convention regarding appearance or dress or struggles to follow common rules of social behavior, such as knowing when to speak or how to take turns while speaking. Many small groups take place in homes where youth less familiar with social conventions are more likely to feel out of place.

Social Isolation

Families of a child or teen with a mental illness are less likely than other families to experience the social interactions that bring them into contact with people who might invite them to church. Multiple factors contribute to their relative social isolation.

Having a child with a mental health condition limits available options for childcare. Parents often have less ability to socialize outside of their homes because children who struggle with self-control, anxiety, and emotional regulation cannot be left with teenage babysitters. Even when childcare is available, out of pocket expenses for mental health care often significantly impact discretionary income.

Children with a broad range of disabilities, including mental health conditions, are less likely to attend private Christian schools where they would be more likely to connect with other families actively engaged at church (Sutton, 2015).

Children with mental illness are less likely to be part of the youth sports culture that facilitates connection between families with common interests. Motor coordination disorder occurs more frequently in children and youth with mental health disorders or developmental disabilities than in the general population (Dewey et al., 2002). Children who are unable to attend a church-affiliated school because of their educational support needs are more likely to lack the athletic skills necessary to thrive in competitive team sports.

Children with common mental health concerns are less likely to have friends to invite them to take part in church-related activities for the reasons described above. Teens with depression often isolate themselves from peers and withdraw from extracurricular activities. A boy with ADHD who frequently interrupts peers while they are speaking, lacks the patience to follow the rules of a game, or struggles to control his temper is less likely to be invited for playdates, birthday parties, and special events. Boys and girls who do not get invited to birthday parties may not be invited to Vacation Bible School.

In a culture where increasing numbers of non-Christians come to church in response to personal invitations, the absence of a substantial social network reduces the likelihood of being invited to church (Nieuwhof, 2019).

Family Experiences of Church

A key determinant of a child's church attendance is their parents' pattern of church attendance and engagement while growing up. A study examining religious service attendance and affiliation among young adults noted the likelihood of an adolescent becoming a weekly church attender in young adulthood is 3.2% if they attend church less than once a month as a teen (Uecker et al., 2016). This statistic highlights the need for effective inclusion strategies for youth with mental health conditions and other disabilities. It also points to the need for an inclusion strategy for parents who experience symptoms of mental illness.

The multigenerational expression of mental illness suggests many children and teens with no experience of church have parents whose church experience was disrupted by their own mental health concerns. Serious mental illness (SMI) is highly heritable. Roughly one in three children of parents with schizophrenia, bipolar disorder, or major depression will develop a serious mental illness—and not necessarily the same mental illness

as their parent (Rasic et al., 2013). A parental history of anxiety (especially maternal history) contributes to a twofold to sevenfold increase in the risk for anxiety in their offspring (Low et al., 2012).

Parental interactions with pastors, church staff, and volunteers when a child or teen experiences mental health-related challenges represent an additional factor impacting family engagement at church. When a child of a parent grounded in the faith has a negative church experience resulting from disability, the family will often seek another church better prepared to support their child's needs. Parents without a strong faith foundation may be less likely to search for a more supportive congregation and need much reassurance before exploring church again.

Discussion: Seven Action Steps for the Church and the Mental Health Professional

Churches engaged in mental health ministry have typically focused on providing counseling and support to individuals who are already part of a church. Lacking are effective models for building connections and relationships with individuals and families not currently attending church. What would a successful inclusion strategy look like for a church seeking to minimize barriers to church attendance and engagement for children and teens with mental health concerns and their families?

. Mental health inclusion would be conceptualized as a mindset, not a program. The goal is to include children and adults with common mental health conditions into worship services, Christian education, small groups, and other activities the church.
. Mental health ministry is, by definition, family ministry. An effective mental health inclusion strategy addresses the needs of everyone in the family, especially the most vulnerable children.
. A good inclusion strategy benefits everyone in the church without requiring anyone with mental health support needs to self-identify. Removing barriers to attendance and engagement should enhance everyone's experience of church.
. Responsibility for mental health ministry is owned by the people of the church who are supported by staff in their personal ministry.
. No church will develop a strategy to include everyone with mental illness, but every church can implement a strategy to welcome more children and adults with mental illness.

The following planning model for mental health inclusion features seven broad strategies designed to identify and address barriers to church attendance and engagement throughout each ministry department. The strategies include following:

1. *Establish a church-wide mental health inclusion team*. The team is composed of leaders with the necessary authority, responsibility, experience, knowledge, gifts, and talents to implement effective outreach and inclusion across all the church's ministries. Senior leadership does not always need to be part of the team so long as they unequivocally endorse the process. Mental health professionals and advocates attending the church, along with occupational therapists, architects, interior designers, social service professionals, and respected members with firsthand experience of mental illness may contribute valuable insights to the team.
2. *Create welcoming ministry environments*. Consider the physical spaces in which ministry takes place. Do the spaces where most teaching occurs promote information retention and learning for all attendees, including those with mental health concerns? Are there unnecessary distractions? How might someone with sensory processing differences experience those spaces? Is the signage throughout the buildings sufficiently clear for attendees who struggle to remember multistep directions? Does the décor in spaces occupied by children and youth help promote self-control?
3. *Prioritize inclusion in activities most essential to spiritual growth*. The typical church emphasizes some activities and practices more than others in the discipleship process. Churches with dynamic and effective teaching pastors may prioritize worship service attendance. For these churches, inclusion efforts might focus on the experience of adults and children during weekend worship times. Churches where small group participation is encouraged might focus on their process for connecting visitors to groups and offer extra training to group leaders. If involvement in community service or missions is encouraged, the team might identify volunteer opportunities for children and adults less comfortable with social interaction.
4. *Develop a mental health communication plan*.

A key component of an effective inclusion strategy involves establishing a church culture in which all attendees are given explicit permission for mental health to be a topic of conversation. In the LifeWay study (2014), the top request of churches from family members of adults with serious mental illness was for pastors to talk about mental health from the pulpit. Churches might consider incorporating mental health-related concerns into pastoral prayers or offering sermons addressing mental-health related topics. Social media platforms are useful tools in combatting negative community perceptions about churches and mental health. Online church services represent a means for congregations to introduce themselves and build connections with families in surrounding communities impacted by mental illness.

5. *Offer practical help in response to heartfelt needs*. Most churches have ministries to provide meals when a family member is in the hospital. Would families from the church receive meals if a child is hospitalized for a psychiatric emergency instead of a medical emergency? Churches can maintain current lists of mental health professionals and treatment facilities to share with attendees in need. They can also help by providing affordable counseling services or peer support or making benevolence funds available for short-term mental health needs, such as one-time consultations or prescription refills. Respite events for families of children with intellectual and developmental disabilities can be redesigned to welcome children with primary mental health disorders and their siblings.
6. *Provide mental health education and support*. For many churches, initiation of an inclusion strategy is the result of education offered to pastors, church leaders, and key volunteers about the needs of families impacted by mental illness. Establishment of mental health support groups is a great starting point for an inclusion strategy and powerful signal to church members and the surrounding community that persons with mental health issues are welcome. Such groups help introduce the church to people who would never otherwise attend a weekend worship service and promote relationships between attendees and members of the community not connected to a church.
7. *Release the people of your church into the community to invite friends and neighbors with mental health concerns*. The most effective mental health inclusion strategy is often the presence of a trusted friend to come alongside someone with anxiety, sensory processing differences, or social communication challenges to help them recognize and avoid potential pitfalls for however long it takes the visitor to acclimate to the church. Staff can celebrate and encourage acts of service and outreach through sharing stories during worship services and on social media platforms.

A mental health-friendly church is characterized by a demonstrable inclusion planning process, mental health education for pastors, church staff, and volunteers, implementation of a mental health communication strategy, provision of tangible assistance to affected individuals and families, and establishment of mental health education and support groups (Grcevich, 2019). Mental health-friendly churches are addressing inclusion in innovative ways:

. One church confronted stigma through presenting a sermon series on biblical teaching regarding anxiety. The same church featured video of a worship band member discussing the impact of his panic attacks and depression on his spiritual life during weekend services and hosted a town meeting in which a psychologist and long-time member of the church joined a pastor on staff and a local pediatrician to address misperceptions about mental illness. The livestream of the town meeting was made available through the church's Facebook page.
. The senior pastor of another church opened worship services with prayer for attendees with depression after the church hosted a training for several hundred volunteers on mental health inclusion. The same church reserves aisle seats next to exits for attendees with panic disorder and produced a video featuring an usher who came to church for the first time once such seating was made available.
. One church appointed a mental health liaison to help acclimate first time visitors with anxiety to the church and interface with ministry leaders when they need additional support.
. A church attended by many families involved

with adoption and foster care ministry noticed a reduction in aggressive behavior during children's ministry activities after reducing the intensity of lighting and repainting their space in more subdued colors.

. A church's founding pastor filmed a video for their social media platforms explicitly extending a welcome to families in the community affected by mental illness in which he shared the struggles his father experienced as a pastor with depression.

. One church opened a mental health resource center staffed during worship services by a member of their inclusion team that features a prominently located booth with free resources from the National Alliance on Mental Illness (NAMI), as well as other educational resources personally vetted by members of the team. The church also makes space available to a local community mental health agency to provide services onsite.

. Hundreds of churches throughout the U.S. have launched Christian-based mental health support groups affiliated with Fresh Hope or the Mental Health Grace Alliance.

. Church members are being trained as "hope coaches"—individuals trained to come alongside attendees going through a difficult situation or a crisis, walking with them, listening, helping them process their pain, fear, and frustrations, and speaking a faith-filled hope into their situations based upon Romans 8:28 (Fresh Hope, 2020).

Conclusion

Families raising children with common mental health conditions such as depression, anxiety disorders, disruptive behavior disorders, and ADHD are far less likely than unaffected families to attend church services regularly and represent a large, underserved people group. Attributes associated with common mental health conditions cause children and families to struggle to meet cultural expectations within the church for social interaction, social communication, and self-control and impact their experience of the physical environments where most ministry takes place. Effective outreach and inclusion with families impacted by chronic mental health conditions is made possible through inclusion strategies designed to help church leaders identify potential obstacles to attendance and engagement in all ministry departments and minimize or eliminate the impact of these obstacles.

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