LIBERTY UNIVERSITY

Assisting Ministry Leaders Managing Bipolar Disorder in Adolescents and Young Adults: Development of an Eight-Week Educational Program

A Thesis Project Report Submitted to

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in Candidacy for the Degree of

Doctor of Ministry

by

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THE DOCTOR OF MINISTRY THESIS PROJECT ABSTRACT

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Bipolar disorder poses significant challenges for individuals and their communities, particularly within religious ministry. This research project addressed the need for an educational program that equips ministry leaders to support adolescents and young adults with bipolar disorder effectively. The Love Faith Church (LFC) in Columbia, South Carolina, serves as the focal point for this study.

This project included the development of an eight-week Ministry Leaders' Educational Plan to educate ministry leaders about bipolar disorder in adolescents and young adults. It emphasized evidence-based research and biblical foundations to help ministry leaders better understand and recognize the signs associated with bipolar disorder. The program further guided leaders in creating a supportive, spiritually nurturing, and cognitively stimulating environment for these individuals.

The study leveraged a mixed-methods approach, encompassing quantitative and qualitative research techniques. Pre- and post-test surveys were conducted to gauge ministry leaders' perspectives and measure changes in knowledge, communication, and leadership abilities. In-depth interviews and focus groups provided qualitative insights into the experiences and opinions of ministry leaders.

This research project bridged a significant gap in the literature by focusing on ministry leaders' experiences in addressing bipolar disorder in adolescents and young adults within a church setting. Doing so addressed the critical need for tailored interventions in this field. The goal was to empower ministry leaders to better serve and support individuals with bipolar disorder, fostering a more inclusive and understanding religious community. In conclusion, this research project represented a vital step toward improving faith communities' mental health support systems. Equipping ministry leaders with the knowledge and skills helped reduce stigma, promote inclusion, and enhance the well-being of adolescents and young adults with bipolar disorder.

Dedication

I would like to begin by giving honor to the Trinity. I would not have started this journey without the guidance and grace of God. As it says in the Bible, “obedience is better than sacrifice” (1 Samuel 15:22).

I would like to express my heartfelt gratitude to the following people who have helped me throughout my journey:

- My husband, Matthew P. Williams: Your unwavering support and encouragement have been the pillars upon which I stand. Your love, like a guiding light, has led me through the darkest tunnels. Your wisdom has been a compass, directing me when I felt lost. In moments of doubt, when I’ve been on the verge of giving up, you’ve gently reminded me that this journey is not merely about me. It’s about a higher calling, a divine purpose that the Lord has set for me. For all these reasons and more, I am deeply grateful. Thank you for being my rock, my guiding star, and my source of strength.

- My son, Damien R. Renfroe, Jr.: This journey would not have been possible without your unwavering faith in me. Your innocent smiles, your endless questions, and your boundless energy have been my source of motivation and strength. Thank you for being my inspiration.

- My daughter, Kayli A. Williams: Your heartfelt prayers each night has been a source of comfort and strength for me. Your unwavering support has been a constant reminder of the bond we share. In times of challenge, your faith has been a beacon, guiding me towards hope and resilience. Your belief in me has fueled my determination and inspired me to persevere. For all these reasons and more, I extend my deepest gratitude. Thank you for being my source of inspiration and my lighthouse amidst the storm.

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- Dr. Lucien Fortier: From the deepest corners of my heart, I extend my sincerest gratitude to you. Your unwavering support from the very inception of this journey has been a beacon of hope for me. The encouraging dialogues we’ve shared have not only uplifted my spirits, but also propelled me forward. Above all, your steadfast belief in me has instilled a confidence that is unshakeable. Thank you for being my pillar of strength.

- To my beloved church: I am profoundly grateful for the opportunity you have given me to pursue this project. Your unwavering support has been a testament to the strength of our community and the power of faith. Your belief in me has been a source of inspiration, driving me to strive for excellence. Your encouragement has fueled my determination, and your prayers have guided me on this journey. Your steadfast support is my fortress, your optimism, my beacon. I cherish your presence in my life. With profound appreciation, I express my gratitude for all these invaluable experiences.

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Abbreviations

DMIN	*Doctor of Ministry*
ESV	*English Standard Version*
LFC	*Love Faith Church*
NLT	*New Living Translation*
YBD	*Youth Bipolar Disorder*

CHAPTER 1: INTRODUCTION

Bipolar disorder is a growing global problem. Bipolar disorder clinical research offers many insights into its causes and implications. Ministry leaders face unique challenges while leading adolescents and young adults with bipolar disorder. Indirect evidence indicates that an individual with bipolar disorder will likely report social isolation and condemnation, contributing to stress, anxiety, and depression.[1] Therefore, it is paramount to develop a program to educate ministry leaders on the unique needs and characteristics of adolescents and young adults who have been diagnosed with bipolar disorder. Using this research, the writer will evaluate how Love Faith Church (hereafter, LFC) in Columbia, SC, can educate its ministry leaders to manage individuals with bipolar disorder better.[2] The research includes an eight-week Ministry Leaders' Educational Plan program to assist ministry leaders in managing adolescents and young adults with bipolar disorder.

The first chapter of the thesis encompasses eight sections and this introduction. The second section briefly introduces the ministry context of the study, whereas the third and fourth sections present the problem and purpose of the thesis. This chapter includes basic assumptions, definitions, limitations, and research delimitations. Finally, the thesis statement summarizes the information presented in the introduction chapter.

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[1] "Bipolar and Isolation | HealthyPlace," (a), https://www.healthyplace.com/blogs/breakingbipolar/2013/09/bipolar-isolation.

[2] This thesis project aims to protect the church, so it uses the pseudonym Love Faith Church.

Ministry Context

Love Faith Church is a local ministry in Columbia, South Carolina. There is a mixed population of believers in the church, with diverse ethnicities and cultures. The goal of outreach events organized by individuals is to reach the unchurched within the community systematically. As part of its ongoing design, the church engages in strategic evangelism, community events, outreach programs, summer of service, camp ignite, worship services, and more. The congregation's support and donations often meet community, city, and world crisis needs. Love Faith Church emphasizes the importance of demonstrating relational love to people, just as Christ shows love to the church. It offers many services to followers, such as college internships, RightNow Media, Bible reading guides, baptism, prayer requests, and child dedication. These services go a long way in strengthening followers' faith and bringing them closer to God.

The church was created in 2006 by four founding families. Between 2006 and 2023, it gradually expanded, attracting more followers, and designing new ministries. It is a relatively large church with many services, and a formal structure. The church's leadership tries to keep up with the times. As a result, it offers many services based on digital technologies, such as RightNow Media.[3] Furthermore, it is essential to emphasize that the church's website is an integral element of its operations since it collects relevant information from followers and offers convenient tools for participating in certain services. For instance, this platform allows followers to register for baptism by choosing an available date.

The current proposed study at Love Faith Church in Columbia, South Carolina, will be an interpretative research project. Following the last census, the city's population is around

[3] "RightNow Media | Streaming Video Library of Bible Studies," accessed Mar 31, 2023, https://www.rightnowmedia.org/accessrnm?utm_source=bing&utm_medium=cpc&utm_campaign=ongoingconversions&utm_content=churchdecisionmakers&msclkid=60ee6ea9a8481fcbe35f0a8e89ab208a.

137,541.[4] The data from the Pew Research Center[5] show that approximately 78% identify as Christians. Others consider themselves Evangelical Protestants (78%), Mainline Protestants (35%), Historically Black Protestants (15%) or Catholics (10%).[6] Baptists currently have the city's largest congregation, while other denominations' influence is much less significant. The available evidence provides a compelling reason to believe that religion plays an essential role in the lives of most residents of Columbia. A recent survey illustrates that 90% of the city's dwellers are "certain" or "fairly certain" in their belief in God, while 85% point out that religion plays an important or somewhat important role in their lives.[7] There are also many other facts indicating religion's importance for Columbia dwellers. Among them, 51% read scripture once a week, 67% feel spiritual peace and well-being due to their faith, and 81% pray to God every week.[8] In light of these findings, it seems justified to state that most people living in Columbia, SC pay significant attention to religion.

The church's website states it tries to help people know God, find meaning in life, and make a difference. Unfortunately, there is no information online on the exact number of followers of the church and their demographic characteristics. Love Faith Church (LFC) mainly interacts with its followers through worship services and life groups, two fundamentally different instruments. The former are large gatherings incorporating many followers, whereas the latter are customized interventions for specific groups that address their unique needs.

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[4] U.S. Census Bureau, "QuickFacts Columbia City, South Carolina," last modified July 1, 2021, https://www.census.gov/quickfacts/columbiacitysouthcarolina.

[5] Pew Research Center, "Adults in South Carolina," last modified 2022, https://www.pewresearch.org/religion/religious-landscape-study/state/south-carolina/.

[6] Ibid.

[7] Ibid.

[8] Ibid.

The church offers many resources to its followers. The Bible reading guide invites people to take a journey of reading the Bible in a year that helps deepen one's knowledge of God. It offers a detailed plan guiding followers through reading the Gospels with a list of specific verses they can read daily. The program is supposed to foster discipline and ensure that people achieve their goal of reading the Bible in a year. The church also invites followers to get baptized. Its website provides a set of available dates so people can register for baptism online. Each church service ends with everyone being able to pray with the church's prayer teams; additionally, they can request customized prayers. Child-dedicated services do not exist as a set of standard procedures. According to the website, parents should contact pastoral team members and collaborate to find the most appropriate way to dedicate their children to meaningful services.

The church allows followers to express their feelings and experiences of how God has affected their lives with the, Share Your Story, online and this information will enable the prayer team to incorporate it into prayers or other church services. College internship services refer to a full-time college internship program combining formal academics with training outside the classroom. The most important parts of this program are leadership training from the fastest-growing churches and Bible classes at the best Christian colleges in the country. Finally, the RightNow Media service is a streaming platform with many faith-based videos.

Interestingly, the church has both an online and an offline campus to appeal to the maximum number of people. Information presented on the official website of Love Faith Church (LFC) is insufficient for conclusions regarding followers' demographic characteristics and distinctive features. Based on the data that was previously mentioned, similarly to other religious people in Columbia, these individuals are likely to express a relatively high religious

commitment and conservatism.[9] The church can assist its ministry leaders with understanding and ministering to youth and young adults with bipolar disorder by providing a focused educational program for their ministry leaders. Furthermore, parents, guardians, and caregivers might request a customized prayer for their unique problems. At the same time, LFC does not have specific resources for leading these adolescents and young adults with bipolar disorder.

The available evidence indicates a compelling reason that followers of Love Faith Church are diverse. Such a pattern is typical for churches operating in South Carolina. Roach reports that Southern Baptist Conventions are becoming increasingly diverse regarding racial and ethnic characteristics.[10] Information provided by the Pew Research Center supports this point of view. There is no agreement among most Southern Baptist churches' followers on several pressing matters. For instance, they disagree on issues such as homosexuality, same-sex marriage, environmental regulations, and human evolution.[11] Such a diverse picture of congregations provides a premise to assert that ministers must design customized interventions to address the needs of their varied followers.

The academic literature does not offer valuable insights into how LFC ministries could assist ministry leaders with adolescents and young adults with bipolar disorder within a church setting. The research by Saxton[12] recently discovered a direct link between family ministry engagement and baptism ratios within the context of the Southern Baptist Convention. The

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[9] Dalia Fahmy, "7 Facts about Southern Baptists," last modified June 7, 2019, https://www.pewresearch.org/fact-tank/2019/06/07/7-facts-about-southern-baptists/.

[10] David Roach, "Count the Faces: SBC Diversity on the Rise," last modified June 11, 2021, https://www.baptistpress.com/resource-library/sbc-life-articles/count-the-faces-sbc-diversity-on-the-rise/.

[11] Pew Research Center, "Adults in South Carolina," last modified 2022, https://www.pewresearch.org/religion/religious-landscape-study/state/south-carolina/.

[12] Kevin Bryce Saxton, "Family Ministry and Evangelism: An Empirical Study of Family Ministry Engagement and Baptism Ratios in the Southern Baptist Convention," Ph.D. dissertation (The Southern Baptist Theological Seminary, 2017).

author emphasizes that a family ministry emphasis is a powerful tool for overcoming various children's problems and helping them stay connected to the church.[13]

Zust et al. provide many examples in their study of how pastors' dedicated efforts helped victims of domestic violence stop blaming themselves for traumatic experiences.[14] The growing emphasis on addressing mental health issues to help followers is evident in many publications featuring churches in South Carolina. For instance, the Southern Baptist Convention issued a resolution on "Mental Health Concerns and the Heart of God" in 2013 in response to mass shootings and suicides.[15] All the examples provided above illustrate that Southern Baptists are becoming increasingly interested in expanding their ministries so that the church would become an integral part of followers' lives and an effective instrument for tackling various problems, including those connected with family issues and mental health problems.

Problem Presented

Bipolar Disorder in the United States

Bipolar disorder is a well-known mental health problem. An individual with bipolar disorder has extreme mood swings, a high suicide rate, sleep problems, and dysfunctional self-esteem (feeling inferior when depressed, superior when manic).[16] At Love Faith Church (LFC), some adolescents and young adults struggle silently and refuse to discuss any issues or complications they have about their illness due to stigma. Mania or hypomania and depression

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[13] Saxton, "Family Ministry and Evangelism: An Empirical Study of Family Ministry Engagement and Baptism Ratios in the Southern Baptist Convention."

[14] Barbara Zust, Jaclyn Housley and Anna Klatke, "Evangelic Christian Pastors' Lived Experience of Counseling Victims/Survivors of Domestic Violence," Pastoral Psychology 66 (2017): 675 (675–87).

[15] Barbara Denman, "SBC Addresses Mental Health Issues," September 1, 2013, https://www.baptistpress.com/resource-library/sbc-life-articles/sbc-addresses-mental-health-issues/.

[16] Markus Rantala, Severi Luoto, Javier Borraz-Leon and Indrikis Krams, "Bipolar Disorder: An Evolutionary Psychoneuroimmunological Approach," *Neuroscience & Biobehavioral Reviews* 122 (2021): 28–37.

are the main symptoms and contribute to elevated levels of stress. At the same time, periods of depression are problematic since they could prevent people from performing their work responsibilities and engaging with loved ones, while extreme cases of bipolar disorder might even lead to suicide.[17] Ministry leaders must recognize, however, that some adolescents and young adults need additional support and design programs to assist them. The severity of bipolar disorder and its potential to cause disastrous consequences are the main reasons behind the growing attention to this mental health problem.

Bipolar disorder is a pressing concern for various stakeholders because of its prevalence and possible implications. According to recent studies, bipolar mood disorders, dysthymic disorders, and major depressive disorders are three of the most common hospitalizations among Americans aged 18 to 44.[18] Bipolar disorder is prevalent in men and women at the age of 20. According to statistics, about 5% of the world's population has bipolar disorder, while 1–2% suffer from bipolar.[19] The number of bipolar disorder cases globally has increased from 32.7 million in 1990 to 48.8 million in 2013, representing a 49.1% increase that is accounted for by aging and population growth.[20] Moreover, even though the disorder remains relatively rare, scientists emphasize that this illness significantly impacts the prevalence of disability in society

[17] Peter Dome, Zoltan Rihmer and Xenia Gonda, "Suicide Risk in Bipolar Disorder: A Brief Review," *Medicine (Kaunas)* 55, no. 8 (2019): 403.

[18] Martin Katzman et al., "Adult ADHD and Comorbid Disorders: Clinical Implications of a Dimensional Approach," *BMC Psychiatry*, 17 (2017): 3.

[19] Emma-Marie Smith, "Bipolar Facts and Statistics: Bipolar Disorder Is Real," *Healthy Place*, December 28, 2021, https://www.healthyplace.com/bipolar-disorder/bipolar-information/bipolar-facts-and-statistics-bipolar-disorder-is-real.

[20] Alize Ferrari et al., "The Prevalence and Burden of Bipolar Disorder: Findings from the Global Burden of Disease Study 2013," *Bipolar Disorders* 18, no. 5 (2016): 441.

because of its early onset, chronicity, and severity.[21] Therefore, bipolar disorder is a pressing problem that deserves the attention of various stakeholders.

The available evidence indicates that the prevalence of bipolar mental disorder is critical for the United States. The study by Post et al. showed that this illness is severe and characterized by long treatment delays in the United States compared to Europe. Furthermore, this illness is associated with more family members suffering from a psychiatric disorder.[22] It seems that this disorder begins at a younger age in the USA. As the scientists explain, approximately two-thirds of all Americans diagnosed with bipolar disorder reported its first signs before the age of 19.

In contrast, the percentage of European patients with such an early offset of the disorder constitutes only around 33%.[23] According to Merikangas et al., the prevalence of bipolar disorder in different countries was 2.4%, accounting for a significant share of the global population, and the USA had one of the highest rates of patients with this mental health problem, 4.4%.[24] While the number of bipolar patients, almost bipolar disorder constitutes a critical problem in the United States that requires a coordinated response from different parties, including the federal and local government, non-government organizations, churches, businesses, and educational institutions.

The amount of information on the prevalence of bipolar disorder in different demographic groups is limited. Additionally, such information primarily relies on old sources. Nevertheless, it still offers some insights valuable for the current study. The data from the

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[21] Ferrari, et al., "The Prevalence and Burden of Bipolar Disorder: Findings from the Global Burden of Disease Study."

[22] Robert Post et al., "More Childhood Onset Bipolar Disorder in the United States than Canada or Europe: Implications for Treatment and Prevention," *Neuroscience & Biobehavioral Reviews*, 74 (2017): 204–13.

[23] Ibid.

[24] Kathleen Merikangas, et al., "Prevalence and Correlates of Bipolar Spectrum Disorder in the World Mental Health Survey Initiative," *Arch Gen Psychiatry* 68, no. 3 (2011): 241–51.

National Comorbidity Survey reveal no statistically significant difference between the exposure of males and females to the risk of developing bipolar disorder.[25] The prevalence of bipolar disorder and severe impairment is estimated at 2.9% and 2.6%, respectively. It has been estimated that adolescent women 3.3% are more likely to develop bipolar disorder 2.6% than their male counterparts based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria assessed impaired functioning.[26] The highest percentage of bipolar patients was reported for the age group between 18 and 29 years old (4.7%), although people between 30 and 44 years old also displayed a high prevalence of this disorder (3.5%).[27] 82.9% of Americans with bipolar disorder report severe impairment, illustrating the disorder's severity.

Moreover, severe bipolar disorder is especially likely to be observed in adolescents. The findings of Merikangas et al. indicate that whereas 2.9% of adolescents in the country had bipolar disorder in 2010, 2.6% of adolescents reported severe impairment.[28] According to the arguments above, adolescents are at risk of developing bipolar disorder.

Bipolar Disorder in Young Adults

This project examines how the Love Faith Church (LFC) can enable its ministry leaders to help lead adolescents and young adults with bipolar's unique challenges. The term "young

[25] Harvard Medical School, "National Comorbidity Survey," August 21, 2017, https://www.hcp.med.harvard.edu/ncs/index.php.

[26] National Institute of Mental Health, "Bipolar Disorder," last modified 2017, https://www.nimh.nih.gov/health/statistics/bipolar-disorder.

[27] Ibid.

[28] Kathleen Merikangas, et al., "Prevalence and Correlates of Bipolar Spectrum Disorder in the World Mental Health Survey Initiative," *Arch Gen Psychiatry* 68, no. 3 (2011): 241–51.

adults" in this project's context refers to those between 18 and 25 years old.[29] In between puberty and age 18, a person becomes more independent and realizes their values, beliefs, and life goals.[30] At this point, an individual with bipolar disorder might face many challenges, such as family problems, issues related to body image, the possible lack of employment or career advancement opportunities, negative stereotyping, defeated expectations, and many others. For individuals with bipolar disorder who lack coping strategies and emotional resilience, these hurdles may become overwhelming.[31] The available evidence provides a compelling reason to believe that young adults who have been diagnosed with bipolar disorder are an example of individuals who are less likely to overcome the challenges that are common for this age group.[32] Therefore, they usually require additional assistance from parents, therapists, friends, ministry leaders, or other parties.

Ministry leaders are essential in helping adolescents and young adults with bipolar disorder live their whole lives and remain productive members. The research by Sullivan et al. emphasizes that family cohesion, adaptability, and conflict within the family context dramatically affect the outcomes of family-focused treatment for bipolar adolescents.[33] In particular, the symptoms of mania display much more significant reductions in adolescents from low-conflict families; furthermore, the scientists consider all three family-related variables as

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[29] Clare Stroud, et al., "Investing in the Health and Well-Being of Young Adults," *Journal of Adolescent Health* 56, no. 2 (2015): 127–29.

[30] Laura Prior et al., "Food Insecurity and Mental Health Problems among a Community Sample of Young Adults," *Social Psychiatry and Psychiatric Epidemiology* 51 (2016): 1073–81.

[31] Stroud, et al., "Investing in the Health and Well-Being of Young Adults," 127–29.

[32] Judith Proudfoot et al., "Triggers of Mania and Depression in Young Adults with Bipolar Disorder," *Journal of Affective Disorders* 143, no. 1–3 (2012): 196–02.

[33] Aimee Sullivan et al., "Family Functioning and the Course of Adolescent Bipolar Disorder," *Behavior Therapy* 43, no. 4 (2012): 837–47.

likely to affect patients' depression scores.[34] Milkowitz advocates for adopting customized treatment strategies for bipolar disorder in late adolescence.[35] The scientist points out that the structure of a family, possible unresolved conflicts, and dysfunctional alliance patterns all significantly impact the outcomes of family-focused treatment of adolescents with bipolar disorder.[36]

The research by Goldstein et al. asserts that it is paramount to stabilize daily rhythms and interpersonal relationships for adolescents at risk for the development of bipolar disorder.[37] Scholars agree that family functioning is crucial in preventing severe bipolar disorder in adolescents. The literature does not offer much information on the unique experiences of ministry leaders who manage adolescents and young adults with bipolar disorder within the church context, as most studies covering family relationships focus on children and adolescents. At the same time, it seems justified to assert that the significance of the church's help is evident.

Young adults who have not overcome their childhood traumas that resulted in the development of bipolar disorder report severer depressive moments, higher functioning impairment, and higher suicide risks.[38] It might be hard to treat their disorder at this point. Issues related to family relationships are included in the risk criteria for bipolar affective disorder in the study by Bechdolf et al., which assists in the identification of bipolar disorder in adolescents and

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[34] Sullivan, et al., "Family Functioning and the Course of Adolescent Bipolar Disorder," 837–47.

[35] David Miklowitz, "Family Treatment for Bipolar Disorder and Substance Abuse in Late Adolescence," *Journal of Clinical Psychology*, 68, no. 5 (2012): 502–13.

[36] Ibid.

[37] Tina Goldstein et al., "Early Intervention for Adolescents at High Risk for the Development of Bipolar Disorder: Pilot Study of Interpersonal and Social Rhythm Therapy (IPSRT)," *Psychotherapy (Chic)*, 51, no. 1 (2014): 180–89.

[38] Clarisse de Azambuja Farias et al., "Clinical Outcomes and Childhood Trauma in Bipolar Disorder: A Community Sample of Young Adults," *Psychiatry Research*, 275 (2019): 228–32.

young adults who are seeking help.[39] The importance of healthy relationships with ministry leaders for an individual with bipolar disorder also could be interpreted from the scientific paper by Geddes and Miklowitz.[40] Even as individuals with bipolar disorder grow up, multiple sources suggest that church ministry leadership still plays an important role in their ability to cope with the illness. In this situation, it seems justified to state that adolescents and young adults with bipolar disorder require help to overcome this illness and their church leaders need to be educated on how to assist them.

Mental Health Problems and the Church

As explained in the previous section of the chapter, churches operating in South Carolina pay an increasingly large amount of attention to the problem of mental health.[41] Churches initiate various interventions to help their followers overcome multiple issues and assist their loved ones with preventing the development of mental health problems. The article by Williams et al. sheds some light on implementing a Mental Health Ministry Committee in African American churches.[42] The scientists found that such a program had the potential to reduce stigma and promote effective treatment of followers who were seeking help with overcoming depression. Moreover, the scholars point out that partnerships with the lead pastor or other church staff members could be a basis for an instrumental community-based participatory approach to reduce

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[39] Andreas Bechdolf et al., "A Preliminary Evaluation of the Validity of At-Risk Criteria for Bipolar Disorders in Help-Seeking Adolescents and Young Adults," *Journal of Affective Disorders* 127, no. 1–3 (2010): 316–20.

[40] John Geddes and David Miklowitz, "Treatment of Bipolar Disorder," *The Lancet* 381, no. 9878 (2013): 1672–82.

[41] "Weekend of Faith for Mental Health." Accessed Mar 31, 2023, https://www.sumtersc.gov/news/weekend-faith-mental-health.

[42] Laverne Williams, Robyn Gorman, and Sidney Hankerson, "Implementing a Mental Health Ministry Committee in Faith-Based Organizations: The Promoting Emotional Wellness and Spirituality Program," *Social Work in Health Care* 53, no. 4 (2014): 414–34.

the prevalence of mental health disorders within the congregation.[43] Robinson et al. show that the African American Church might be a powerful mechanism for ensuring the mental health of black males by providing culturally relevant, spiritually sensitive, and gender-specific services addressing particular mental health issues.[44]

This project illustrates the importance of customization in developing effective interventions for protecting the mental health of specific groups of followers. Bornsheuer et al., in turn, assert that Christian church members appreciate their church's role in shaping followers' mental health.[45] Individuals with bipolar disorder argue that they come to the church when seeking care, talk to knowledgeable practitioners about their mental health problems, and apply certain religious practices in mental health counseling. All these activities help them prevent the development of mental health disorders.

The literature offers many insights into ministers' role in addressing their congregations' mental health issues. Still, no specific programs exist that can be useful to ministry leaders. The study by Nadkarni and Fristad indicates that those whose children have bipolar disorder often display a pattern of social isolation.[46] In particular, the scientists found that such an individual with bipolar disorder often distance themselves from church ministries. Such an outcome is unfortunate because, as the scientists explain, church groups could support these people and help them implement effective treatment strategies for children.

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[43] Williams, Gorman, and Hankerson, "Implementing a Mental Health Ministry."

[44] Michael Robinson et al., "Black Male Mental Health and the Black Church: Advancing a Collaborative Partnership and Research Agenda," *Journal of Religion and Health* 57 (2018): 1095–07.

[45] Jennifer Bornsheuer, Richard Henriksen, and Beverly Irby, "Psychological Care Provided by the Church: Perceptions of Christian Church Members," *Counseling and Values* 57, no. 2 (2012): 199–13.

[46] Radha B. Nadkarni and Mary A. Fristad, "Stress and Support for Parents of Youth with Bipolar Disorder." *The Israel Journal of Psychiatry and Related Sciences* 49, no. 2 (2011): 104.

Furthermore, recent evidence suggests that many churches have created a network of adequate mental health services customized to their needs and address various disorders.[47] It could be observed from the research by Cruz et al.,[48] that religion plays a vital role in shaping the experiences of people with bipolar disorder. The problem is Love Faith Church's ministry lacks resources to assist ministry leaders in recognizing possible bipolar disorder signs in adolescents and young adults.

Purpose Statement

The purpose of this DMIN action research project is to develop and deploy an educational program for ministry leaders about bipolar disorder in adolescents and young adults. With the church becoming overloaded with responsibilities, ministry leaders give minimal priority to mental health problem issues. There is no better place to address issues, seek refuge, and receive guidance than the church. People seeking mental health treatment consult youth pastors, ministers, and lay leaders as the first resort. Still, the lack of trust between ministering leaders and the body of the church prevents education regarding bipolar disorders. Ministry leaders can achieve positive results through theological and psychological monologue when addressing faith and bipolar disorders.

The researcher developed a ministry leaders' education program for eight weeks to educate them about bipolar disorder in adolescents and young adults and how they may be able to recognize signs associated with bipolar disorder to create a spiritual, emotional, and

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[47] Rosalyn Denise Campbell and Tenesha Littleton, "Mental Health Counselling in the Black American Church: Reflections and Recommendations from Counsellors Serving in a Counseling Ministry," *Mental Health, Religion & Culture* 21, no. 4 (2018): 336–52.

[48] Mario Cruz et al., "The Relationship between Religious Involvement and Clinical Status of Patients with Bipolar Disorder," *Bipolar Disorders* 12, no. 1 (2010): 68–76.

cognitively stimulating environment within their ministry. In week one, ministry leaders will learn about bipolar disorder. Week two will focus on recognizing signs of bipolar disorder among adolescents and young adults. As part of the third, fourth, and fifth weeks of this course, ministry leaders will learn biblical principles related to mental health from a biblical perspective. Ministry leaders will learn about sensory overload symptoms during week six, how to be aware of individuals with bipolar disorder as leaders, and how to take self-care actions when ministering to adolescents and young adults with bipolar disorder. It is intended that week seven will provide ministry leaders with an overview of educational programs that have already been implemented, and week eight will be the culmination of the educational program. Using the Ministry Leaders' Education Plan, Love Faith Church's ministry leaders can assist individuals with bipolar disorder more effectively in their ministry roles.

Despite numerous studies investigating bipolar disorders, little study has focused on ministry leaders' experiences in addressing this problem in adolescents and young adults in churches, and this issue is not systematically studied. As a result, there is an evident research gap concerning the church's role in educating ministry leaders about bipolar disorder. The current thesis will address the gap with the unique strategies church ministry leaders could employ to help advance their knowledge and experiences.

Basic Assumptions

Based on the researcher's findings, the following presuppositions underly the problem. According to this project, ministry leaders who lead adolescents and young adult members of the Love Faith Church's congregation demonstrate dedication to a relatively high religious commitment. Such an assumption directly originates from the data provided by Pew Research

Center.[49] It is unlikely that the *Ministry Leaders' Educational Plan* will give positive results for leaders who do not emphasize leadership enhancement.

The researcher assumes that ministry leaders who have experience working with adolescents and young adults with bipolar disorder are sincerely committed to helping them manage their bipolar disorders. Many studies distinguish between an individual with bipolar disorder seeking and not seeking help; therefore, if all adolescents and young adults seek support would have been erroneous.[50] Adolescents and young adults with bipolar disorder should be treated sincerely by their parents, guardians, caregivers, and physicians. Still, they must also care for themselves mentally, and church ministry leaders must know how to assist. Therefore, the assumption seems justified.

The third assumption of the study is that ministers and other church leaders are also willing to help followers overcome bipolar disorder problems. Church leaders need basic knowledge of this illness and an understanding of how critical it is to support adolescents and young adults with bipolar disorder. Finally, the last assumption of the study pertains to internet usage. Most ministry leaders who are members of Love Faith Church's (LFC) congregation have some devices that allow them to access online resources and possess basic computer skills. Participating in the educational program focus group forms the basis of the project, so this assumption is crucial.

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[49] Pew Research Center, "Adults in South Carolina," last modified 2022, https://www.pewresearch.org/religion/religious-landscape-study/state/south-carolina/.

[50] Andreas Bechdolf et al., "A Preliminary Evaluation of the Validity of At-Risk Criteria for Bipolar Disorders in Help-Seeking Adolescents and Young Adults," *Journal of Affective Disorders* 127, no. 1–3 (2010): 316–20.

Definitions

Anxiety Disorders. Anxiety disorders are characterized by extreme nervousness, panic, or phobias. Persons suffering from anxiety disorders cannot calm down, feel panicky much of the time, and have physical symptoms of constant nervousness. Those with post-traumatic stress may experience flashbacks of trauma and may react to loud noises or other reminders of the precipitating event.[51]

Bipolar Disorder. Bipolar disorder is "a mental health disorder characterized by extreme shifts in mood, high suicide rate, sleep problems, and dysfunction of psychological traits like self-esteem (feeling inferior when depressed and superior when manic)."[52]

Caregiver Burden. Caregiver burdens are the challenges people experience while caring for children with bipolar disorder.[53]

Church Counseling. Church counseling refers to a specific type of therapy based on traditional therapeutic methodologies and religious belief practices.[54]

Church Leaders. Church leaders are individuals responsible for "overseeing" the church, such as pastors, administrators, and others.[55]

Mental Disorder. Major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder comprise four of the top ten causes of disability in developed countries.

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[51] Tim Clinton and Ron Hawkins, The Quick-Reference Guide to Biblical Counseling: Personal and Emotional Issues (Grand Rapids, MI: Baker Books, 2009), 163.

[52] Markus Rantala et al., "Bipolar Disorder: An Evolutionary Psychoneuroimmunological Approach," *Neuroscience & Biobehavioral Reviews* 122 (2021): 28–37.

[53] George Karambelas et al., "A Systematic Review Comparing Caregiver Burden and Psychological Functioning in Caregivers of Individuals with Schizophrenia Spectrum Disorders and Bipolar Disorders," *BMC Psychiatry* 22, no. 1 (2022): 422.

[54] Mark Weston, *Creating a Church Counselling Ministry* (Scotts Valley: CreateSpace Independent Publishing Platform, 2016), 25.

[55] Noel Clavecilla, *The Anatomy of Church Leaders* (Eugene: Wipf and Stock Publishers, 2020), 75.

Multiple mental disorders are common among people.[56] A mental disorder is associated with thoughts and behaviors that cause individuals to experience severe problems in significant areas including relationships, employment, education, financial well-being, and even spirituality. Mental disorders are not short-term, but they are also not necessarily permanent. Mental problems must endure for a certain minimum period before a mental disorder becomes diagnosable. Most mental disorders resolve after treatment with counseling and medication or simply the passing of time. Other lifelong mental disorders cause ongoing problems for those afflicted and their families. If someone is mentally ill, they are not merely "odd." Labels of mental disorders ought never to be applied without a professional assessment. Mental disorders are severe disturbances.[57]

Mood Disorders. Mood disorders are those that primarily affect a person's emotional stability. The most common are depression and bipolar disorder (formerly manic depression). Individuals afflicted with depression feel discouraged and hopeless almost every day, have lost interest in activities they used to enjoy, and sometimes consider or attempt suicide. Those with bipolar disorder exhibit cycles of wildly changing emotions and behaviors.[58]

Personality Disorders. Personality disorders are disturbances in thinking and behavior that are of a person's essential character, resulting in lifelong counterproductive patterns.

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[56] Tim Clinton and Ron Hawkins, The Quick-Reference Guide to Biblical Counseling: Personal and Emotional Issues (Grand Rapids, MI: Baker Books, 2009), 163.

[57] Ibid.

[58] Tim Clinton and Ron Hawkins, The Quick-Reference Guide to Biblical Counseling: Personal and Emotional Issues (Grand Rapids, MI: Baker Books, 2009), 163.

Unlike the above mental disorders, personality disorders do not often respond to medications or short-term therapy.[59]

Young Adults. The group is people between 18 and 25 years old.[60]

Limitations

This study will have to contend with limits likely to affect the validity of its findings. Several factors may affect the project, starting with limited access to information. Most parents do not disclose that their adolescent or young adult has the bipolar disorder. Additionally, most guardians living with adolescent and young adult bipolar disorder diagnosed with bipolar disorder are not likely to share important details about their illnesses with ministry leaders. Since the researcher will interview each ministry leader participant separately, gathering information from a large study sample will be time-consuming. Due to the project's objective to design an educational resource program, the proposed project will also have limited resources. Church and ministry leaders need access to resources for managing adolescents and young adults with bipolar disorder, such as support groups, case studies, and training materials. These resources are difficult to obtain due to limited access. Other limitations of the current study include the difficulty in generalizing the results. Since the participants will come from one city, along with the church's online ministry leaders, the results may not apply to other contexts or people.

Moreover, ministry leader participants may be biased due to their self-selection or refusal to participate in the project. The researcher may not have enough participants for the

[59] Clinton and Hawkins, The Quick-Reference Guide to Biblical Counseling, 163.

[60] Clare Stroud et al., "Investing in the Health and Well-Being of Young Adults," *Journal of Adolescent Health* 56, no. 2 (2015): 127–29.

project if ministry leaders withdraw during the research process. Lastly, since this project will not occur in the church, the church may not accept the training due to its minor importance.

Delimitations

This study's delimitations intentionally aim to limit the extent to which the limitations above derail and hamper the study's validity and credibility by ensuring the study's scope remains attainable and feasible. Firstly, the study will focus on assisting ministry leaders in managing young adults diagnosed with bipolar disorder residing in South Carolina, with other locations not being included, to ensure the scope of the research remains attainable. In addition, since time and financial constraints will prevent us from conducting large-scale fieldwork, the researcher will only conduct individual surveys, interviews, and focus groups. Thirdly, the results only apply to the studied population and should not be generalized to other groups, addressing the generalizability limitation. When interpreting the data, the researcher will also consider the possibility of bias due to participants' self-selection.

Thesis Statement

Historically, the church, parents, guardians, caregivers, and family members of those with mental disorders received criticism instead of support. Parents, guardians, caregivers, adolescents, and young adults report condemnation and social isolation from family gatherings, church, community events, and extended social networks due to a mental disorder's challenging behavior and stigma.[61] Parents often develop anxiety and depressive symptoms associated with

[61] Radha Nadkarni and Mary A. Fristad, "Stress and Support for Parents of Youth with Bipolar Disorder," *The Israel Journal of Psychiatry and Related Sciences* 49, no. 2 (2011): 104.

chronic stressors comparable to those described for caregivers of people with dementia.[62] Among the Love Faith Church (LFC), the mission is to educate ministry leaders about adolescents and young adults with the bipolar disorder and how they can address their challenges. Ministry leaders will be better equipped in assisting adolescents and young adults by using the Ministry Leaders' Education Plan. If LFC implements an eight-week ministry leader educational program, then ministry leaders will be able to create a spiritual, emotional, and cognitively stimulating environment for church members.

[62] Farshid Shamsaei et al., "Family Caregiving in Bipolar Disorder: Experiences of Stigma," *Iranian Journal of Psychiatry* 8, no. 4 (2013): 188–94.

CHAPTER 2: CONCEPTUAL FRAMEWORK

Identifying the prevalence of bipolar disorder among adolescents and young adults, Chapter 2 will provide an overview of the literature review, theological and theoretical foundations. Understanding bipolar illness concepts, such as hope, religious beliefs, connections, reliability, compassion, and multiple approaches, adds to ministering leaders' knowledge. To better understand bipolar disorder and the responsibilities of the church, it is appropriate to conceptualize it historically. This literature review will consist of an in-depth analysis of several scholarly articles that provide an understanding of the illness, perspectives, theories, arguments, and practices that serve as a framework for understanding the church's role.

Literature Review

Mental illnesses are a widespread threat to communities and public health in the U.S. and abroad.[1] People of all ages are affected by this healthcare challenge, including children, and older people. Various social agencies have enacted measures to improve public mental health to mitigate the severe impacts of mental disorders on people's quality of life. For example, religious establishments and healthcare institutions have developed programs that prevent, treat, or manage mental illness.[2] Young adults are more likely to suffer from mental disorders than older adults, even though depression is prevalent in all age groups. Most youths encounter several

[1] Linda Rosenberg, "Behavioral Disorders: The New Public Health Crisis," *The Journal of Behavioral Health Services & Research* 39, no. 1 (–01, 2012): 1–2, doi:10.1007/s11414–011–9265–8.

[2] Mildred M Reynolds, "Religious Institutions and the Prevention of Mental Illness," *Journal of Religion and Health* 21, no. 3 (1982): 245–53, http://www.jstor.org/stable/27505686.

social stressors they are not equipped to handle. As a result, they are likely to develop anxiety, depression, or bipolar disorder. Religious groups are crucial in addressing bipolar disorder, even though healthcare systems are primary care providers.

The Prevalence of Mental Problems Among the Youths

Recent studies indicate that bipolar disorder is a widespread concern worldwide. According to Cook, common mental conditions affect 20% adults worldwide, while between 1 and 7% of adults suffer from severe cases of these disorders.[3] The author adds that 10 to 20 % of adolescents and children report mental disorders, with most issues beginning at 14.[4] With one in every five adults having mental conditions, these disorders represent a significant public concern worldwide. Additionally, 10 to 20% of adolescents and children reporting mental disorders reveal the widespread mental conditions in adults and the growing population. Nevertheless, young people exhibit more signs of these bipolar conditions than adults.

Bipolar disorder is also prevalent healthcare challenge among global young people. In their study in Canada, Church, Ellenbogen, and Hudson found that one in five young people in the country is affected by a mental health disorder.[5] In their research in Ukraine, Burlaka et al. found that about 26.13% and 5.45% of involved participants had lifetime suicidal ideation and suicide attempt, respectively.[6] Since this evidence comes from different countries, it

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[3] Christopher Cook, "Mental Health in the Kingdom of God," *Theology*, 123, no. 3 (2020), 164, https://doi.org/10.1177/0040571X20910700.

[4] Ibid.

[5] M. Church, S. Ellenbogen, and A. Hudson, "Perceived Barriers to Accessing Mental Health Services for Rural and Small City Cape Breton Youth," *Social Work in Mental Health* 18, no. 5 (September 2020): 1, doi:10.1080/15332985.2020.1801553.

[6] Viktor Burlaka et al., "Suicidal Behaviors Among College Students at a Bible Belt University: The Role of Childhood Trauma, Spirituality, Anxiety, and Depression," *Best Practice in Mental Health* 16, no. 2 (Fall 2020): 1–20, https://search.ebscohost.com/login.aspx?direct=true&db=ofm&AN=147164288&site=ehost-live&scope=site.

demonstrates that mental health disorders are a widespread problem among youths worldwide. The studies reveal that more than 20% of young people suffer from at least one form of mental illness in various parts of the world.

This is similar in the U.S., where millions of young people meet the criteria for a mental health disorder. The U.S. has a considerably high occurrence of bipolar disorders among older adolescents and young adults. In a 2019 World Health Organization report, Burlaka et al. observed that suicide, one of the signs of bipolar disorder, is a leading cause of death among young adults and late adolescents in the U.S., with 16% of this group reporting suicide ideation or suicide attempt.[7] Additionally, Cadigan, Lee, and Larimer estimate that 22% of U.S. youths meet the requirements for a mental health condition, with more than 2.5 million reporting mental health services in the past year.[8] With more than 7.6 million of its youth population suffering from mental illnesses and 16% of this group having suicide ideation or suicide attempt, the U.S. has widespread cases of mental health disorders. One of these mental conditions affecting youths is bipolar disorder.

The Prevalence of Bipolar Disorder Among Young People

Recent studies indicate that the U.S. has a high rate of bipolar disorders. According to Rowland and Marwaha, approximately 1% of the population has a person who has bipolar disorder.[9] In their study, Sulley, Ndanga, and Mensah found that mood disorder is a leading

[7] Burlaka, et al., "Suicidal Behaviors Among College Students at a Bible Belt University."

[8] Jennifer Cadigan, Christine M Lee, and Mary E Larimer, "Young Adult Mental Health: A Prospective Examination of Service Utilization, Perceived Unmet Service Needs, Attitudes, and Barriers to Service Use," *Prevention Science: The Official Journal of the Society for Prevention Research* 20, no. 3 (April 2019): 366–76, doi:10.1007/s11121–018–0875–8.

[9] Tobias Rowland and Steven Marwaha, "Epidemiology and Risk Factors for Bipolar Disorder," *Ther Adv Psychopharmacol*, 8, no. 9, (2018), 251.

cause of morbidity and mortality, with young people recording the highest occurrence at about 17 years.[10] Although one percent is a fraction of the total cases of mental health disorders in the U.S., the figure still represents a concerning number of people. This percentage indicates that more than 3.3 million young Americans have bipolar disorder. As one of the leading causes of mental illness and mortality among young people, bipolar disorder is a significant public health concern.

According to Sulley, Ndanga, and Mensah, bipolar disorders in America vary from one race to another. For example, Native American and European populations have higher recurrent and single Major Depressive Disorders. At the same time, the rate of manic and bipolar episodes is considerably high among the African Americans and Caucasians demographic groups than other racial groups.[11] This evidence indicates that some races are more prone to bipolar disorder than others. The Caucasian population records the highest cases of bipolar disorders, followed by the African American demographic groups. To mitigate the impact of this mental health condition, healthcare institutions have initiated some programs that improve public mental well-being such as, group and family therapy, support groups, intensive outpatient care, partial hospitalization, and psychiatric medications and outpatient medical management.[12]

[10] Saanie Sulley, Ndanga Memory, and Nana Mensah, "Pediatric and Adolescent Mood Disorders: An Analysis of Factors that Influence Inpatient Presentation in the United States," *International Journal of Pediatrics and Adolescent Medicine* 9, no. 2, (2022), 90.

[11] Saanie Sulley, Ndanga Memory, and Nana Mensah, "Pediatric and Adolescent Mood Disorders: An Analysis of Factors that Influence Inpatient Presentation in the United States," *International Journal of Pediatrics and Adolescent Medicine* 9, no. 2, (2022), 91.

[12] "Types of Mental Health Services | Mental Health Treatment Programs," accessed April 29, 2023, https://www.psychguides.com/mental-health-disorders/treatment/types/.

Church and People with Bipolar Disorder

Religion impacts mental health and illness depending on the belief system.[13] Amedome and Bedi say religious groups began offering compassionate care to vulnerable individuals, such as mentally ill people.[14] During the fourteenth century, church-sponsored and priest-supervised hospitals were established for mental health patients.[15] Since mental health services started from the compassionate care of the religious group, churches played the foundation role in this healthcare practice. Additionally, the early churches sponsored and managed the early healthcare institutions that provided services to people with mental problems. Despite scientific advances, many people with mental health conditions still visit churches.

Studies demonstrate that some religious organizations still assist mentally ill patients. While citing a 2006 World Health Organization report, Amedome and Bedi note that about 98 percent of people with mental health problems in Ghana attend traditional healing shrines and prayer camps to recover from the conditions.[16] In his U.K. study, Anyinsah observes that many Christians seek assistance from their leaders without extra contact from mental health practitioners.[17] Although people in most developing nations, such as Ghana, embrace modern treatment approaches, many view religious leaders as the solution to their mental health disorders. Anyinsah's study demonstrates that even people in developed nations seek assistance

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[13] Prakash B.Behere, et al., "Religion and Mental Health," *Indian Journal of Psychiatry* 55, no. Suppl 2 (–1, 2013): S187-S194. doi:10.4103/00195545.105526, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC370568/.

[14] Sedem Nunyuia Amedome, and Innocent Kwame Bedi, "The Effects of Religion and Locus of Control on Perception of Mental Illness," *Journal of Religion and Health* 58, no. 2 (April 2019): 653–65, doi:10.1007/s10943–018–0658–3.

[15] Ibid.

[16] Ibid.

[17] J. E. Anyinsah, *A Cooperative Inquiry: An Investigation into the Training Needs of Christian Leaders Supporting Congregants with Mental Health Issues Receiving Treatment*, ProQuest Dissertations & Theses Global, (2021): 7.

from religious leaders. Confidence in religious leaders hinges on the positive impacts on people's mental well-being.

Religion is associated with a longer, healthier life, according to scholars. According to Amedome and Bedi, people with strong religious affiliations report more life satisfaction, greater realization of life goals, and less psychological distress.[18] The evidence indicates that affirming belief in God may contribute to better physical and psychological health than non-believers. Although bipolar disorder affects every group, the higher health status of people with strong religious affiliations reduces the mental challenges among this group. Early in the development process, this role is often assumed.

Ministry leaders shape cultural values and identities that help with this mental health condition. According to Amedome and Bedi, various cultural and personal aspects of identity, including religious beliefs significantly influence individuals' early development.[19] However, Arango notes that most bipolar conditions develop during their development because they are mentally vulnerable.[20] Due to this emotional vulnerability, ministry leaders provide them with solid beliefs that strengthen their mental capacity. By shaping the youths' identity through religious beliefs, ministry leaders play a preventive role in the fight against bipolar disorder conditions. As a result, these leaders develop the mental strength to help manage mental health disorders throughout their lives. These ministry leaders help adolescents and young adults manage their bipolar disorders by providing emotional support during episodes.

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[18] Amedomeand and Bedi, "The Effects of Religion and Locus of Control on Perception of Mental Illness."

19 Ibid.

[20] Arango Celso et al., "Preventive Strategies for Mental Health," *The Lancet Psychiatry* 5, no. 7 (2018): 591–604, doi:10.1016/S2215–0366(18)30057–9, https://www.sciencedirect.com/science/article/pii/S2215036618300579.

While quoting Tepper et al., Amedome and Bedi write that 92% of mentally ill patients reported using religious activity to cope with the difficulties and symptoms of their condition.[21] The authors also cite Koenig et al.'s study, which found that half of the people interviewed used a religious practice or belief to cope with mental illness.[22] Ministry leaders share with the people hope and faith that helps the congregants cope with life's difficulties, including cognitive problems. With a belief or practice to embrace, congregants with bipolar disorder conditions have a mechanism to alleviate suffering. When the church does not have a program to assist ministry leaders with the bipolar crisis, they face several limiting factors.

Scholars against the involvement of religion in mental health treatment and management are a factor limiting the church's role with their ministry leaders in assisting people with bipolar disorder. Amedome and Bedi write that the postulations of Freud and twentieth-century scholars regarding the neurotic influences of religion significantly eroded the church's positive impact in addressing mental health.[23] Scholars with this school of thought argue that religious beliefs are responsible for developing schizophrenia, depression, and low self-esteem. Anyinsah observes that mental health help services question Christian ministry leaders' role in caring for people with these disorders.[24] This doubt about the value of religion in addressing bipolar disorder conditions erodes people's confidence in their spiritual leaders. The limited counseling knowledge and training among church ministry leaders fuel this opposing argument.

The lack of professional training on mental conditions limits the role of religious leaders in assisting people with bipolar disorder. According to Anyinsah, most religious leaders feel

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[21] Amedomeand and Bedi, "The Effects of Religion and Locus of Control on Perception of Mental Illness."

[22] Ibid.

[23] Ibid.

[24] Anyinsah, A Cooperative Inquiry, 7.

insufficiently equipped to collaborate with healthcare practitioners to treat mental challenges because they lack proper mental health literacy.[25] The author adds that these leaders are reluctant to cooperate with a hostile system.[26] Although Anyinsah conducted this study in the U.K., ministry leaders in the U.S. do not undertake sufficient training programs to handle bipolar and other mental health conditions. Without this knowledge, church ministry leaders' collaboration with experienced and highly skilled medical practitioners leads to discomforting encounters for the former. Untrained ministry leaders are also unpopular with some individuals with bipolar disorder.

Young people with bipolar disorder are reluctant to seek assistance, limiting the role of ministry leaders. According to Campbell, young adults with mental health conditions, such as depression signs, hesitate to seek help because they believe such action will negatively impact various aspects of their life, including employment.[27] A stigma associated with bipolar disorder makes some young people afraid to seek help, according to the author. The tendency to avoid visiting a ministry leader to receive support for mental health disorders means that religious groups have minimal impact on assisting people with bipolar illness. Church organizations cannot help those with bipolar disorder due to a lack of resources and this behavior.

According to Cachiaras, religious groups in the U.S. participate in several hospitality activities, including supporting the prison community, sheltering people experiencing homelessness, helping people during disasters, combating human trafficking, and assisting

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[25] Anyinsah, A Cooperative Inquiry, 7.

[26] Ibid.

[27] Anthony David Campbell, "Clergy Perceptions of Mental Illness and Confronting Stigma in Congregations," *Religions* 12, no. 12 (2021): 1110, https://go.openathens.net/redirector/liberty.edu?url=https://www-proquest-com.ezproxy.liberty.edu/scholarly-journals/clergy-perceptions-mental-illness-confronting/docview/2612835349/se–2.

people with drug addiction.[28] However, drug additions and the homeless population have rapidly increased in recent years.[29] The evidence demonstrates that spreading their resources to support all these social groups and the rapid increase in social challenges, such as homeless people, have stretched the resources in these religious formations. With inadequate resources, churches cannot serve their congregants with bipolar disorders effectively, contributing to an increase in the number of untreated bipolar disorders.

Scholars have extensively investigated the role of religious leaders and the healthcare system in treating mental health conditions. These studies reveal that the healthcare system in the U.S. has developed some treatment options for mentally ill patients seeking clinical interventions. However, the religious community has been essential in helping those with mental health conditions. Nevertheless, the U.S. healthcare system and religious groups face numerous challenges that hinder their effectiveness in addressing mental illnesses such as bipolar disorder. For example, the U.S. healthcare system has understaffed with mental health practitioners. Additionally, the large volume of people admitted to hospital due to substance abuse means that these institutions divert some resources from mental health programs.

Religious groups also do not have sufficient resources to meet the growing needs for their services. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) provides care to the ever-increasing population of homeless and substance users.[30] Additionally, they provide services to the prison community and people impacted by natural

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[28] Ben Cachiaras, "What Should the Church Do about the Mental Health Crisis? Christian Standard," https://christianstandard.com/2022/07/what-should-the-church-do-about-the-mental-health-crisis/.

[29] Doran Kelly, Callan Elswick Fockele, and Marcella Maguire, "Overdose and Homelessness—Why We Need to Talk About Housing," *JAMA Network Open*, 5, no. 1 (2022): 2–4 1001/jamanetworkopen.2021.42685.

[30] "Homelessness Programs and Resources," accessed Apr 29,2023, https://www.samhsa.gov/homelessness-programs-resources.

disasters.[31] As a result, these entities cannot provide adequate care to people with bipolar disorder. The researcher hopes to fill this gap by developing a Ministry Leaders' Educational Plan to improve ministry leaders' ability to minister to adolescents and young adults with bipolar disorder.

This chapter shows that an individual with bipolar disorder requires long-term care. However, religious groups and hospitals do not address mental conditions like bipolar disorder. As far as this project, no study has examined how ministry leaders can contribute to treating and managing the mental health of adolescents and young adults with bipolar disorder with this condition.

Why Hospitals Do Not Offer Solutions to People with Bipolar Disorder

The U.S. healthcare system is the primary care provider for people with bipolar disorder. According to Yee et al., the FDA has approved several drugs, including lithium or olanzapine, to help treat acute mania episodes of bipolar disorder.[32] The federal agency also approved Lurasidone in 2018 to help treat major depressive episodes in BD-I disorder among teenagers and young adults. Yee et al. also notes that medical practitioners use antipsychotics and anticonvulsants to help manage and treat bipolar disorders.[33] This evidence demonstrates that the U.S. healthcare system has developed the necessary drugs to assist patients with this mental health condition. Most people seek clinical help when facing bipolar disorder problems, and

[31] "Disaster Preparedness, Response, and Recovery," accessed Apr 29, 2023, https://www.samhsa.gov/disaster-preparedness.

[32] Caitlin Yee et al., "Maintenance Pharmacological Treatment of Juvenile Bipolar Disorder: Review and Meta-Analyses," *International Journal of Neuropsychopharmacology*, 22 no. 8, (2019), 532.

[33] Ibid.

hospitals use these treatment options to help patients control their emotions. However, medical institutions struggle to care for these patients for several reasons.

The limited number of mentally ill-trained practitioners suggests that healthcare institutions do not help churches provide care to people with bipolar disorder. According to Tikkanen et al., all adults suffer from at least one mental condition, such as anxiety, depression, or experience emotional distress.[34] Despite this growing problem, the authors note that the country has a low supply of mental health practitioners, such as psychiatrists and psychologists, with only a third of the U.S. primary care institutions having a professional in the mental disorder field.[35] The high mental health burdens and the shortage of employees mean that the U.S. healthcare system does not have sufficient resources to address mental conditions comprehensively. As a result, people not receiving care from religious organizations do not obtain quality assistance from the healthcare system. The challenges associated with diagnosing this condition complicate the treatment of the disorder.

The long-term nature of bipolar disorder treatment and the challenge in early diagnosis means that healthcare institutions cannot provide comprehensive care to people with bipolar if the church fails to take this role. Although timely diagnosis, sufficient understanding, and reliable short and long-term treatment are critical to treating this mental disorder, Baldessarini, Vázquez, and Tondo write that the healthcare system hardly performs these tasks appropriately. The author adds that bipolar disorder comes alongside other co-occurring psychiatric conditions,

[34] Tikkanen Roosa et al., "Mental Health Conditions and Substance Use: Comparing U.S. Needs and Treatment Capacity with Those in Other High-Income Countries," *The Commonwealth Fund*, https://www.commonwealthfund.org/publications/issue-briefs/2020/may/mental-health-conditions-substance-use-comparing-us-other-countries.

[35] Ibid.

including anxiety and disabilities.[36] Without early diagnosis and the proper short- and long-term treatment, most people with this healthcare challenge do not recover from the disorder. Therefore, healthcare institutions do not provide the best avenue to relieve religious organizations of the mental illness burden. People who do not receive care from ministry leaders will likely not obtain long-term care from medical institutions. These limitations stem from various mental-related complications that these hospitals must address.

The ever-high substance abuse cases divert healthcare resources from bipolar disorder treatment programs, leaving religious groups with a significant mental illness burden. Tikkanen et al. note that substance use disorder is a substantial cause of death, killing about nine people in every million deaths in the U.S.[37] Other studies indicate that the U.S. healthcare system admitted 66 patients due to substance use in every 10,000 patients in 2019.[38] At the same time, more than 21.4 million Americans met the diagnostic criteria for drug abuse disorders in 2015.[39] Although the number of deaths related to substance use is considerably low, the number of people admitted to hospital due to this condition is significantly high. Due to this high number, medical institutions cannot work effectively with resource-strapped religious groups to provide adequate mental health care. Without healthcare systems and religious groups overstretched, the church requires a new approach to leading and caring for these individuals with bipolar disorder through their ministry leaders.

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[36] Baldessarini Ross, Gustavo Vázquez, and Leonardo Tondo, "Bipolar Depression: A Major Unsolved Challenge," *International Journal of Bipolar Disorder*, 8, no. 1. (2020), 1–13.

[37] Tikkanen, et al., "Mental Health Conditions and Substance Use."

[38] Jonathan Cantor et al. "Analysis of Substance Use Disorder Treatment Admissions in the US by Sex and Race and Ethnicity Before and During the COVID–19 Pandemic," *JAMA Network Open*, 5 no. 9 (2022): 1.

[39] Thomas McLellan, "Substance Misuse and Substance Use Disorders: Why Do They Matter in Healthcare?" *Transactions of The American Clinical and Climatological Association,* 128, (2017): 115.

The new approach aims to develop a plan to help leaders guide adolescents and young adults with bipolar disorder. The researcher will work with the ministry leaders with a Scripture-based educational program to help improve their leadership among adolescents and young adults with this disability. Ministry leaders who encounter people suffering from bipolar disorder have a better chance of taking measures to improve their lives since bipolar disorder is a long-term illness. Instead of solely relying on healthcare practitioners, ministry leaders will have sufficient knowledge to provide assistance with this mental condition. Against such challenges relating to access to mental health care, individuals with bipolar disorder present diverse issues that demand increased care and attention to ensure improved well-being and life quality and prevent problem aggregation.

The Role of Family in Bipolar Disorder Care

Bipolar disorder is among the mental health problems that trigger patients to develop suicidal thoughts and tendencies, demanding frequent and constant care. Approximately 20–30 times more likely to commit suicide are patients with mental illnesses, including bipolar disorder, according to a systematic review Miller and Black conducted to explore the relationship between bipolar disorder and suicide.[40] Suicidal thoughts and attempts are higher among bipolar patients who are unemployed, male, living alone, younger (< 35 years), divorced, and have no child. The relationship between living alone and having no children with increased suicidal thoughts and attempts among bipolar disorder patients demonstrates that this group of people with this mental problem demands regular and constant care and social support. Regular and

[40] Jacob N Miller and Donald W. Black, "Bipolar Disorder and Suicide: A Review," *Current Psychiatry Reports* 22 (2020): 1–10.

continuous care from a family member may provide these individuals comfort and love and reduce suicidal thoughts and tendencies.

Besides Miller and Black's study, Dome, Rihmer, and Gonda's brief review confirm that bipolar disorder patients have high suicidal tendencies, increasing the need for immediate care. The authors observed that suicidal thoughts and behaviors are frequent among bipolar disorder patients, and up to 4–19% of these individuals end their life during their illness cycle. Additionally, 20–60% of bipolar disorder patients attempt to end their life through suicide at least once in their lifetime.[41] The risk of suicide within this population is 10–30 times higher than those without mental health problems. Like Miller and Black's study, Dome, Rihmer, and Gonda's review also confirmed that bipolar disorder patients who are under 35 years, divorced, living in social isolation, separated from spouses, unmarried, and male are highly likely to commit suicide. These findings further confirm the need for increased care and social support among bipolar disorder patients to reduce the risk of suicide.

Social and emotional support is valuable among bipolar patients and can reduce suicidal thoughts and attempts. Owen et al. conducted a study in the United Kingdom to determine how social support may contribute to suicidal thoughts among bipolar disorder patients. According to the survey, most participants viewed social support as a source of defeat, alienation, hopelessness, and entrapment for bipolar disorder patients.[42] However, within four months, social support changed an individual with bipolar disorder perceptions and significantly reduced suicidal ideation and attempts. These findings confirm that with adequate social support, bipolar

[41] Peter Dome, Zoltan Rihmer, and Xenia Gonda, "Suicide Risk in Bipolar Disorder: A Brief Review," *Medicina* 55, no. 8 (2019): 403.

[42] Owen, Rebecca et al., "Directly or Indirectly? The Role of Social Support in the Psychological Pathways Underlying Suicidal Ideation in People with Bipolar Disorder," *International Journal of Environmental Research and Public Health* 19, no. 9 (2022): 5286.

disorder patients are less likely to feel alienated, defeated, and hopeless and experience suicidal thoughts and attempts. Other studies have supported the role of social support in reducing suicidal ideation among bipolar disorder patients.

Several research studies have suggested that social support among bipolar disorder patients may reduce suicidal ideation, including Turton et al.'s systematic review and investigation of emotional dysregulation. In the study, the authors found that feelings of hopelessness and difficulties with social connectedness trigger emotional pain among bipolar disorder patients and result in suicidal ideation.[43] However, when such individuals with bipolar disorder experience social connectedness, they overcome feelings of hopelessness and alienation, contributing to improved emotional regulation and reduced suicidal ideation. Turton et al. presented generalizable findings across contexts as a systematic review. These findings confirm Owen et al.'s observation that social support can improve bipolar patients' emotional well-being and reduce suicidal ideation and attempts. Besides suicidal ideation, medical non-adherence is a pressing issue among bipolar disorder patients.

Bipolar disorder patients have a high tendency for medical non-adherence and need constant care to improve their treatment adherence and promote their mental stability and well-being. While investigating non-adherence to treatment among patients with bipolar disorder in Jammu, India, Manhas et al., found that among 109 patients participating in the study, the prevalence of medication non-adherence was approximately 59.6%.[44] These patients recorded poor treatment outcomes and increased frequency of recurrent depressive episodes. Generalizing

[43] Holly Turton et al., "The Relationship Between Emotion Dysregulation and Suicide Ideation and Behavior: A Systematic Review," *Journal of Affective Disorders Reports* 5 (2021): 100136.

[44] Rameshwar S. Manhas et al., "Prevalence of Non-Adherence to Treatment Among Patients of Bipolar Affective Disorder," *Journal of Medical Science and Clinical Research* 7, no. 6 (2019): 623–28.

these findings in the broader population demonstrates that around half of bipolar disorder patients are non-adherent to treatment, increasing the disorder burden related to this mental health problem in the population. Non-adherence to therapy among bipolar disorder patients is not a problem in India alone but is prevalent globally.

Jawad et al.'s narrative review study confirms Manhas et al.'s findings that treatment non-adherence is a frequent problem among bipolar patients, triggering increased care. In their review involving 103 studies published in different databases, Jawad et al., narrative study revealed that the prevalence of medication non-adherence among bipolar disorder patients is approximately 50%.[45] Additionally, in European countries, treatment non-adherence among bipolar disorder patients can reach up to 57%. These findings correlate with Manhas et al.'s study and demonstrate that medical non-adherence among bipolar disorder patients is not a location-specific problem but a global concern. Approximately 50% of bipolar disorder patients do not adhere to their medications, so they need to be provided with increased support and care to trigger adherence and reduce the social burden caused by this disorder. Although diverse strategies can promote treatment adherence among bipolar disorder patients, social support is more cost-effective, straightforward, and readily available.

In different societies worldwide, family, friends, and the church community are essential in caring for individuals with bipolar disorder challenges. For example, Marshall et al., observe that in the United Kingdom, approximately 8.8 million people care for friends, relatives, and other close social contacts with mental health issues.[46] The UK healthcare policy recognizes the

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[45] Ibrahim Jawad et al., "Medication Nonadherence in Bipolar Disorder: A Narrative Review," *Therapeutic Advances in Psychopharmacology* 8, no. 12 (2018): 349–63.

[46] Paul Marshall et al., "Caring for a Family Member with Psychosis or Bipolar Disorder Who Has Experienced Suicidal Behaviour: An Exploratory Qualitative Study of an Online Peer-Support Forum," *International Journal of Environmental Research and Public Health* 19, no. 22 (2022): 15192.

contribution care providers outside the healthcare system make towards improved mental health in the country. Additionally, September and Beytell contend that in most countries, public psychiatric hospitals and healthcare facilities focus on the care and rehabilitation of mentally ill patients requiring specialized healthcare. After discharge, these individuals with bipolar disorder rely on community-based care, especially from friends and family members.[47] Significant scientific literature supports the importance of the church, family, and friends in caring for patients with bipolar disorder.

Pakpour et al., is a randomized controlled trial that provides foundational literature supporting that family-based interventions can promote medication adherence among bipolar disorder patients. Pakpour et al., is a randomized controlled trial in Iran to determine how a multifaceted intervention can promote medication adherence among bipolar disorder patients.[48] The multidimensional intervention involved integrating brief Motivational Interviewing (MI) sessions, psychoeducation, and family engagement efforts. Within the experimental group that participated in the multifaceted intervention, patients reported improved medication adherence at the end of the program. Although the family engagement component plays a more significant role in collectivist Middle Eastern cultures than in Western capitalist societies, Pakpour et al.'s study demonstrates that its role in promoting medication adherence among bipolar disorder patients is undisputed.

Loots et al.'s systematic review and meta-analysis study provide generalizable findings supporting that family provides social support that enhances medication adherence among

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[47] Uwarren September and Anna-Marie Beytell, "Family Members' Experiences: People with Comorbid Bipolar and Substance Use Disorder," *International Journal of Mental Health and Addiction* 17 (2019): 1162–79.

[48] Amir H. Pakpour et al., "Promoting Medication Adherence Among Patients with Bipolar Disorder: A Multicenter Randomized Controlled Trial of a Multifaceted Intervention," *Psychological Medicine* 47, no. 14 (2017): 2528–39.

bipolar disorder patients. In this study, the researchers included 42 studies involving 2967 people with schizophrenia and 1271 bipolar disorder patients for the systematic and meta-analysis.[49] The researchers observed that in the reviewed studies, family members with schizophrenic or bipolar disorder patients received education about the importance of medication adherence and the risks of discontinuing treatment. The review revealed that while teaching family members complex interventions was challenging, providing them with booklets about treatment adherence triggered them to support their schizophrenic and bipolar disorder patients, resulting in improved medication adherence. While there is good literature to support the role of the family in reducing suicidal ideation and attempts and improving medication adherence among bipolar disorder patients, church ministries and families lack the resources and training to fit in their position.

Caring for relatives with bipolar disorder can be challenging and significantly burdens family members. In a study to investigate the experiences of family members caring for a relative with bipolar disorder in the United Kingdom, Marshall et al., observed that care providers experience burdens and challenges equally when caring for their relatives with bipolar disorder.[50] Most family care providers reported increased anxiety due to the fear that their family members with bipolar disorder may experience aggregated illness outcomes and commit suicide. The constant fear and anxiety among care providers that they would lose their loved ones due to bipolar disorder-mediated suicide caused them distress and hopelessness. Such constant distress and fear burden care providers and could gradually affect their well-being and quality of life.

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[49] Elke Loots et al., "Interventions to Improve Medication Adherence in Patients with Schizophrenia or Bipolar Disorders: A Systematic Review and Meta-Analysis," *International Journal of Environmental Research and Public Health* 18, no. 19 (2021): 10213.

[50] Marshall, et al., "Caring for a Family Member with Psychosis or Bipolar Disorder Who Has Experienced Suicidal Behaviour: An Exploratory Qualitative Study of an Online Peer-Support Forum," 15192.

Family-based care providers are more likely to experience declined overall health due to the burden of caring for their relatives with bipolar disorder. Marshal et al., observed that most family-based care providers grappled with the responsibility of guaranteeing the safety and well-being of their relative with bipolar disorder.[51] They reported struggling with the need to provide the best care to the extent of neglecting their well-being as they experienced challenges balancing their needs and provision of care. Parents taking care of their children with bipolar disorder were the most affected because they experienced emotional distress while struggling to help their loved ones. In their systematic review, Fekadu et al., also confirmed that parents caring for their children with bipolar disorder reported a high depression score.[52] These findings highlight the struggles family-based care providers experience when caring for their relatives with bipolar disorder. They struggle to balance their needs and well-being and the responsibility to guarantee the safety and well-being of their sick relatives. The burden is overwhelming because most families with bipolar disorder patients have limited support access, especially during crises.

Although family-based care intervention for bipolar disorder reduces the strain on national healthcare resources, these families receive limited to no support during crises. In Marshall et al.'s qualitative study in the UK, respondents who were family-based care providers for bipolar disorder relatives reported that caring for individuals with bipolar disorder demands dealing with suicidal crises that are cyclical and frequent and demand urgency. However, during such suicidal crises, care providers struggle to find support, especially from police and healthcare

[51] Marshall, et al., "Caring for a Family Member with Psychosis or Bipolar Disorder Who Has Experienced Suicidal Behaviour: An Exploratory Qualitative Study of an Online Peer-Support Forum," 15192.

[52] Wubalem Fekadu et al., "Multidimensional Impact of Severe Mental Illness on Family Members: Systematic Review," *British Medical Journal Open* 9, no. 12 (2019): e032391.

practitioners. The lack of support leaves family-based care with a significant burden to care for and ensure the safety of relatives with bipolar disorder. Since family-based care providers may lack formal training, handily, suicidal crises can be challenging and distressing.[53] Besides the emotional and psychological cost, family-based care providers experience a considerable economic burden.

Families living with and caring for bipolar disorder patients experience considerable economic devastation when they cannot access external material support. The careers of people with bipolar disorder, and psychosis, experience negative financial impacts due to the constant need for healthcare services.[54] The study systematically analyzed severe mental health problems by Fekadu et al., to investigate their multidimensional implications for family members. Since mentally ill patients primarily depend on care providers, treatment costs and informal care result in significant economic distress for a family. One of the studies in Fekadu et al.'s systematic review demonstrated that the annual out-of-pocket medical expenses among caregivers of bipolar disorder patients ($93.93) were higher than among other mental illnesses ($64.8).[55] Since most care providers caring for relatives with bipolar disorder may fail to work to find time for care, they may run into financial distress. To aggregate the economic burden and a lack of support, families living with relatives with bipolar disorder experience alienation in society.

Caring for a family member with bipolar disorder can be exhausting despite the importance due to the stigma it attracts. While investigating stigma experiences among families living with relatives with bipolar disorder in Iran, Latifian et al. observed that these families

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[53] Marshall, et al., "Caring for a Family Member with Psychosis or Bipolar Disorder Who Has Experienced Suicidal Behaviour: An Exploratory Qualitative Study of an Online Peer-Support Forum."

[54] Ibid.

[55] Fekadu, et al., "Multidimensional Impact of Severe Mental Illness on Family Members: Systematic Review," e032391.

experienced diverse stigmatization.[56] They experienced labeling, social isolation, and social deprivation. Families with such characteristics experienced rebuke from community members and struggled to interact with other societal members. The burden of social stigma, isolation, and social deprivation can burden providers of these individuals with bipolar disorder. They may not abandon their child due to bipolar disorder and may choose to endure stigmatization and social isolation. The social stigma and isolation issues associated with bipolar disorder are not a problem solely for Middle East cultures.

Bipolar disorder stigma and social isolation affect patients and their families in Western cultures. Reupert et al., found stigma among people with mental illnesses to be a social problem with negative ramifications in their integrative review.[57] Parents of youths with bipolar disorder experience considerable stigmatization and isolation in diverse societies, including Australia, Canada, the United Kingdom, and Denmark. Reupert et al., examined stigmatization among families of mentally ill patients in several countries, which indicates how widespread this problem is. Stigma reveals the aggregated challenges that families with relatives with bipolar disorder experience. These challenges and issues in bipolar disorder demonstrate an increased need for support to help such families care for their loved ones.

Family involvement in bipolar disorder is well established. Still, little research has explored how churches can lead adolescents and young adults with this mental illness. Family members, especially parents, are a source of vital support and care for patients with bipolar

[56] Maryam Latifian et al., "The Process of Stigma Experience in the Families of People Living with Bipolar Disorder: A Grounded Theory Study," *BMC Psychology* 10, no. 1 (2022): 1.

[57] Andrea Reupert et al., "Stigma in Relation to Families Living with Parental Mental Illness: An Integrative Review," *International Journal of Mental Health Nursing* 30, no. 1 (2021): 6–26.

disorder, and their position is irreplaceable and undisputed.[58] However, against such understanding, the reviewed literature demonstrated that family-based care providers caring for patients with bipolar disorder had limited access to support. Additionally, most studies have focused on how family-based care providers living with relatives with bipolar disorder can receive support from formal institutions and healthcare facilities. Limited literature has examined how church ministry leaders can manage and support young adults with bipolar disorder. Many theological foundations position the church as responsible for addressing bipolar disorder challenges in societies.

Theological Foundations

Nature of Doctrine

Most studies on bipolar disorder problems globally have paid more attention to the statistics without considering the effects of these challenges on adolescents and young adults. Bipolar disorder problems have gained more attention due to their high occurrence and incidence rates. However, more important than these statistics is how these problems contribute to human suffering. Behind these statistics are suffering, disoriented, hurting, and traumatized individuals with bipolar disorder who are torn inward and withdrawn from their families, friends, and communities to live lonely and hopeless lives.[59]

The book of Genesis provides a framework to guide the church in caring for people with mental illness, including bipolar disorder. The first five books of Scripture, identified as the Pentateuch, are normative resources rooted in Moses' authority in the Bible. Established for the

[58] Marshall, et al. "Caring for a Family Member with Psychosis or Bipolar Disorder Who Has Experienced Suicidal Behaviour: An Exploratory Qualitative Study of an Online Peer-Support Forum," 15192.

[59] Cook Christopher, "Mental Health in the Kingdom of God," *Theology* 123, no. 3 (2020) 163–71.

sustenance of the Israel community of faith and life, the Pentateuch provides instructions for proper communal living. In Genesis 1:27, God created humanity in His image; this biblical verse affirms the positive role of humankind in all creation.[60] *The Pulpit Commentary* further asserts that the verse does not specify that only those physically and mentally healthy people are the ones that bear the image of God:

> So (or *and*) God created (*bara*, as in vers. 1, 21, *q. v.*) man (literally, the *Adam* referred to in ver. 26) in his own image, in the image of God created he him; male and female created he them. The threefold repetition of the term "created" should be observed as a significant negation of modern evolution theories as to the descent of man and as the emphatic proclamation of his Divine original. The threefold parallelism of the members of this verse is likewise suggestive, as Umbreit, Ewald, and Delitzsch remark, of the jubilation with which the writer contemplates the crowning work of Elohim's creative word. Murphy notices two stages in man's creation, the general fact stated in the first clause of this triumphal song and the two particulars—first, his relation to his Maker, and second, his sexual distinction—in its other members. In the third clause, Luther sees an intimation "that the woman also was created by God, and made a partaker of the Divine image, and dominion over all."[61]

Humans are created in God's image rather than in man's image. Based on this argument, mentally ill people, including people with bipolar disorders, are God's children and deserve care. While bipolar disorder problems are not a challenge for unbelievers, there are difficulties plaguing believers. As such, church leaders have a responsibility to care for and support those in the church who suffer from this condition.

In Matthew 4:23, Jesus taught in the synagogues of Galilee, preached the message of the kingdom, and healed every disorder and affliction that was prevalent there. The word *therapeuo* means "to heal," "to cure," or "to restore." This participle describes a means to cause someone to

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[60] Lerner Asia, "Uniquely Gifted: A Theology of Mental Illness for Inclusive Ecclesiology," *Selected Honors Theses* 96, (2018), 24.

[61] Spence-Jones, ed., *Genesis*, vol 1, *The Pulpit Commentary* (London; New York: Funk & Wagnalls Company, 1909), 30.

recover health, often with the implication of caring for such a person.[62] John Peter Lange and Philip Schaff's commentary supports the argument that the church is responsible for overseeing the church:

> A description of its peculiar mode follows the general sketch of Christ's sphere of activity. Conforming to Jewish custom, He appeared as a traveling Rabbi in the various synagogues of Galilee—the συναγωγή (from συνάγω, the congregation), in the Sept. for עֵדָה and קָהָל. The name embodied the idea that each temple represented the congregation of Israel as a whole, just as some Christians designate each Christian community a church, embodying and describing the whole church.[63]

Although it has been challenging to establish a distinctive Christian language and approach to mental health considering the highly clinical issue, the church's role in promoting mental well-being is undisputed. As a result, the church cannot alienate itself from these issues and how they affect people and societies.

Mental Health and Sin

According to an article on the American Psychological Association (APA) website, faith-based institutions such as churches, synagogues, and mosques are increasingly partnering with psychologists to improve the mental health of their congregants. This suggests that within various belief systems, there is a diverse range of attitudes towards mental illness, and it is not universally seen as a result of personal transgressions or sins.[64]Although the story of David in Psalm 51 and 1 Kings 12 demonstrates that mental illness can result from evil deeds, Elijah's

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[62] David Abernathy, *An Exegetical Summary of Matthew 1–16*, *Exegetical Summaries* (Dallas, TX: SIL International, 2013), 93.

[63] John Peter Lange and Philip Schaff, *A Commentary on the Holy Scriptures: Matthew* (Bellingham, WA: Logos Bible Software, 2008), 95.

[64] Weir, Kirsten. "Reaching Out to the Faithful." Accessed Oct 27, 023. https://www.apa.org/monitor/2020/04/reaching-faithful.

physiological condition documented in 1 King reveals that this challenge can affect anyone.[65] Many people suffer from mental or physical illnesses due to chemical imbalances in their bodies. As a result, the church cannot view mentally ill people as individuals God has condemned due to sins. While it could be easier to think that believers are immune to mental health disorders, the assumption would be misinformed because the stigma and suffering of such challenges exist as much inside the church as outside. Believers are as susceptible as non-believers to bipolar disorder, contrary to the belief that they are above such struggles.[66] The presence of mental health challenges among the believers makes the church a central institution and Christians critical stakeholders in supporting mentally ill persons and helping societies overcome these issues. Additionally, even if believers were immune to mental health problems, the church would have a duty to help non-believers overcome mental illness to win them and expand God's kingdom.

Grcevich emphasizes the inseparability of the church from mental health and the argument that mental illness does not result from a lack of belief in God. According to his commentary, church leaders can be essential allies for those suffering from bipolar disorder conditions.[67] The church has been integral to communities for centuries, offering social support and resources to people who require healing and relief. The book *Mental Health and the Church* explores how churches can assist in reaching out and helping people who struggle with ADHD, anxiety, and other mental health issues.[68] By recognizing seven barriers to church attendance,

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[65] Maddox Austin, "What Does the Bible Say About Mental Illness? The Ethics and Religious Liberty Commission of the Southern Baptism Convention," 2018.

[66] Grace Theological Seminary, "Mental Health, and the Church," last modified, November 1, 2021, https://seminary.grace.edu/mental-health-and-the-church/.

[67] Stephen Grcevich, *Mental Health and the Church* (Grand Rapids: Zondervan Academics, 2018).

[68] Ibid.

such as stigma, fear, and differences in social communication, the book presents a comprehensive plan for effectively ministering to suffering people.[69] With compassion, love, and guidance, churches can become a place of acceptance, understanding, and hope for people with mental health challenges, encouraging them to be open about their struggles and equipping them with the necessary skills and support to thrive.

The Compassion of God and the Church

Cook, explored the intersection between biblical teachings and mental health. He argues that religion can be a powerful source of support for people struggling with mental disorders. He emphasizes the importance of psychiatry's engagement with religion to understand better how individuals with bipolar disorder may find strength and hope in their faith.[70] The author examines how sacred texts like Ezekiel from the 6th-century BC Hebrew prophet may reveal important insights about the connections between religion and mental health.[71] Cook encourages further debate about this topic in a constructive, critical, and sensitive manner to advance the understanding of mental health in the religious context. Ultimately, the author believes that meaningful dialogue on religion and mental health can empower an individual with bipolar disorder to develop healthier and more balanced approaches to coping with a mental disorder.

Although Scripture does not mention bipolar mental illness, it includes human suffering like those of people with these disorders. Psalm 34:18 and Psalm 145:18 demonstrate how God comforts those suffering, near death, depressed, and brokenhearted. Roman 8:28 encourages people to believe that God is working for the good of those who love Him. Although

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[69] Stephen Grcevich, *Mental Health and the Church* (Grand Rapids: Zondervan Academics, 2018).

[70] Christopher Cook, "Psychiatry in Scripture: Sacred Texts and Psychopathology," *The Psychiatrist* 36, no. 6 (2012): 225–29.

[71] Ibid.

Lamentations 3:31–33 indicates that God can bring grief, He also shows care and unwavering love to all human beings.

Mental health problems have broad signs and symptoms; people with these conditions face struggles and suffering. Bipolar disorder causes suffering and pain and undermines individuals with bipolar disorder's quality of life in healthcare. Since God is closer and cares for vulnerable people, the church cannot retreat from mental health issues and suffering. Those who look upon the ministry leaders for guidance and hope to overcome life challenges would be disappointed if they did not discuss their bipolar disorder problems.

Unless the church helps people overcome their bipolar disorder challenges, it will be fighting the same principles it upholds. In Luke 4, Jesus proclaimed that He came to release the captives, set free the oppressed, and recover the sight of the blind. From this statement, Maddox suggests that Jesus' ministry is for the vulnerable people in society, and His role was to reverse the conditions.[72] The church is built on Jesus Christ's teaching to spread the good news to everyone. As a result, the church is responsible for ensuring that vulnerable social groups, including individuals with bipolar disorders, receive the necessary care for their condition and have a flourishing wholeness. Therefore, the church is central in promoting respect for people with bipolar disorders because its goal is to continue what Jesus began.

Church's Stigma Around Bipolar Mental Health

Today, bipolar disorder problems are a significant cause of societal inequality and disequilibrium. As a result, they disproportionately affect disadvantaged and marginalized members of society, such as the poor, homeless, ethnic, and racial minorities, prisoners, and

[72] Autin Maddox, "What does the Bible Say About Mental Illness? The Ethics and Religious Liberty Commission of the Southern Baptist Convention," 2018.

people with disabilities. Bipolar disorder problems attract social stigma, prejudice, and social exclusion condemning victims to suffer and substandard life.[73] In his commentary, Bruyn notes believers take a new, shared identity as one new humanity in Christ. While citing Gal. 3:28, the author notes that time has passed pride, ethnicity, and partiality because all people are equal before the eyes of the Lord.[74] According to these scriptures, the church needs to assist vulnerable people in society in experiencing the same joy as believers. Therefore, the church cannot abide by its principles without addressing bipolar disorder challenges and how they affect disadvantaged society members. New relationships with God result in new horizontal relationships with others. Christ removes racial, economic, and gender barriers and all other inequalities. All are equal in Christ and united in the gospel. The gospel does not add anything or become optional but applies equally to all. The Gospels are about these things.[75]

If the church decides to separate mental illnesses itself from adolescents and young adults with bipolar disorder, it would be detrimental to the church. According to a study investigating the sources of care for drug and alcohol use, Wong et al., found that individuals, including believers and non-believers, view religious leaders and the church as critical sources of support to overcome life challenges, including mental illnesses. The study further revealed that among U.S. adults diagnosed with mental health challenges 25% of them preferred to turn to religious leaders or the church for help. Hays' studies also confirmed that individuals with mental health problems are likelier to turn to their ministry leaders and church before seeking medical

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[73] Christopher, Mental Health in the Kingdom of God, 163–71.

[74] Bruyn David, "A Theology of Equality," *Religious Affections* (2018), https://religiousaffections.org/featured/a-theology-of-equality/.

[75] G. Walter Hansen, *Galatians*, The IVP New Testament Commentary Series (Downers Grove, IL: InterVarsity Press, 1994), Ga 3:28–29.

treatment.[76] These research findings support the idea that individuals with mental health problems trust that their ministry leaders and church are a source of help to overcome such struggles. As a result, the church would make such individuals hopeless and undermine their purpose in life if it decided to avoid the issue of mental health challenges like bipolar disorder.

The church stands to lose nothing by addressing mental health struggles among its believers and non-believers. Living with a mental health problem does not make an individual a sinner. Bipolar disorder problems are earthly struggles that affect human life. However, while some ministry leaders believe that mental health problems can stem from worldly influence and sinful behaviors that rob people of the joy and contentment of life, the church would be wrong to alienate itself from the suffering of the people.[77] It must spread humility and love and invite all people into God's kingdom to relieve them of the burdens of earthly struggles. Therefore, whether bipolar disorder challenges are sins or not, the church must help individuals with bipolar disorder overcome these challenges and attain the joy and contentment of life.

Addressing Bipolar Disorder in the Church

While there is theological justification about why the church should participate in the community to address mental health challenges, in most cases, it is hesitant to take its place and help people attain mental wellness. In 95% of cases, pastors report that the church has the skills and tools to help families overcome mental health challenges, including suicidal thoughts. [78]

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[76] Krystal Hays, "Reconceptualizing Church-Based Mental Health Promotion with African Americans: A Social Action Theory Approach," *Journal of Religion & Spirituality in Social Work: Social Thought* 37, no. 4 (2018): 351–72.

[77] Jannette Berkley-Patton et al., "Engaging the Faith Community in Designing a Church-Based Mental Health Screening and Linkage to Care Intervention," *Metropolitan Universities* 32, no. 1 (2021): 104–23.

[78] Grace Theological Seminary, "Mental Health, and the Church," https://seminary.grace.edu/mental-health-and-the-church/.

However, only 4% of congregants globally indicate that their pastors were aware of individuals struggling with mental health challenges.[79] Additionally, most mentally ill congregants feel unsupported by their church, and few religious leaders are willing to speak openly about mental health problems. Since most mentally ill individuals turn to the church for assistance and the church has a responsibility to help people overcome life struggles, this religious institution must take its position. The church has diverse interventions it can adopt to help people overcome bipolar disorder problems.

Supporting adolescents and young adults with bipolar disorder requires more than comfort and prayers; the church must take a more comprehensive approach. Although prayers are vital in recovering people with mental health issues, the church's mentally ill persons, including those with bipolar disorder, need social support or a strategy to recover. While describing the famous faith without action as dead (James 2:17), James noted that Abraham needed to perform some work to have a fulfilled life.[80] Although Paul affirmed the need for prayers and comfort in helping individuals overcome life challenges, including mental health problems,[81] ministry leaders require a practical strategy to ensure people with these disorders are recovering. These church-centered activities can help individuals with bipolar disorder problems get into the recovery process. Therefore, ministry leaders must combine prayers with practical actions to help people with bipolar disorder.

The church can integrate prayers, comfort, and other material support to help communities and individuals deal with mental health challenges. While God can heal anybody of

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[79] Grace Theological Seminary, "Mental Health, and the Church," https://seminary.grace.edu/mental-health-and-the-church/.

[80] What Does It Mean, "Faith Without Works Is Dead? *Verse by Verse Ministry International,* 2016.

[81] Steve Bloem, The Pastoral Handbook of Mental Illness: A Guide for Training and Reference. United States (Kregel Academic, 2018).

any disorder or illness through prayers and faith, he often uses doctors, other healthcare practitioners, and medicines as tools to help. Doctors and other practitioners, including psychiatrists, are God's vessels to help humans overcome the suffering that stems from disorders and illnesses, including mental health challenges.[82] Christian ministry leaders can also be medical practitioners without contaminating their faith and belief in God. As a result, the church and healthcare system share the same core goal of addressing bipolar disorder problems and helping people to overcome worldly challenges. The church can provide material support to allow people access to treatment to overcome mental health challenges.

Even though bipolar disorder issues are clinical rather than spiritual, as argued in this thesis, ministry leaders can play a meaningful role in addressing these issues. A person with bipolar disorder endures pain and suffering, which the church cannot ignore. The church has a responsibility to help people overcome the grief of mental health challenges. People with bipolar disorder suffer from pain due to mental health problems. Such people need social support through prayers, hospitality, and resources. A common goal of this thesis is to explore how the church and its ministry leaders can use the educational program to work together to minister to adolescents and young adults with bipolar disorder. The *Baker Encyclopedia of Psychology & Counseling*[83] explains:

> Bipolar disorder is so named because those afflicted with it experience both mania and depression, unlike those with unipolar disorders, who experience only one extreme, usually depression. There are two types of bipolar disorders, Bipolar I and Bipolar II; Bipolar I experiences both mania and depression; in Bipolar II, the individual experiences hypomania and depression. Mania or hypomania is the key to diagnosing bipolar disorder. A person who experiences a manic state even once is presumed to have bipolar disorder. Individuals with bipolar disorder may undergo more episodes of depression than

[82] Cook, Mental Health in the Kingdom of God, 163–71.

[83] C. D. Dolph, "Bipolar Disorder," *Baker Encyclopedia of Psychology & Counseling*, ed. David G. Benner and Peter C. Hill, (Grand Rapids, MI: Baker Books, 1999), 145.

> manic episodes, and they may have long intervals between attacks of each. Some individuals, known as rapid cyclers, experience four or more episodes yearly.

These individuals with bipolar disorder often seek spiritual guidance from their churches and faiths in emotional distress. Many Christian churches still stigmatize mental illness, and a culture of silence coupled with misguided attitudes and erroneous beliefs often makes suffering believers feel ashamed, blamed, and isolated.[84] Many factors contribute to the stigma associated with bipolar disorder in the church. Ivory Smith Causey's journal states, "People with mental illness had a stigma attached as having personality disorders, and curses, demons, or evil spirits were caused by mental illness in her church community."[85] Regardless of personal opinions and beliefs, individuals with bipolar disorder need compassion from the church (James 2:1), truth (John 17:17), and abundant life (John 10:10) despite their illness. Birmaher argues that young:

> People with bipolar disorder usually have recurring episodes of major depression, but "depressive episodes are not necessary for making the diagnosis." For some, mania is the primary symptom, and one of the first signs of bipolar disorder is "mood dysregulation — the child is angry or depressed one moment, then is excited and happy and full of ideas moments later.[86] The Australian Psychological Society disagrees, saying, "Despite the recognized average age of onset for bipolar disorder occurring during youth, the diagnosis remains controversial. Rates of diagnosis of bipolar disorder have risen significantly over the past decade, leading some clinicians and researchers to question if every day adolescent issues or other forms of psychological difficulties are mistaken for bipolar disorder"[87]

Furthermore, there are no neurobiological reasons that bipolar disorder cannot occur in young people. Despite this research evidence, although some clinicians do not accept that bipolar

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[84] Robyn Henderson-Espinoza, "The Silent Stigma of Mental Illness in the Church," accessed Mar 18, 2023, https://sojo.net/articles/silent-stigma-mental-illness-church.

[85] Ivory Smith Causey, "Coping with Bipolar Disorder within My Faith Community | NAMI: National Alliance on Mental Illness," (July 15, 2019), https://www.nami.org/Blogs/NAMI-Blog/July–2019/Coping-with-Bipolar-Disorder-within-My-Faith-Community.

[86] Jane Brody, "The Challenges of Bipolar Disorder in Young People - the New York Times," July 6, 2021, https://www.nytimes.com/2021/07/05/well/mind/bipolar-disorder-young-people.html.

[87] "Bipolar Disorder in Young People," *Australian Psychological Society* 34, (February, 2012), https://psychology.org.au/for-members/publications/inpsych/2012/feb/04-bipolar-disorder-in-young-people.

disorder can occur in younger people, there is a consensus that bipolar disorder does occur in youth.[88] Several research groups have been established, maintained, and strongly supported the diagnosis of youth bipolar disorder, including the University of Washington's Barbara Geller research group, the University of Illinois' Mani Pavuluri research group, and the National Institutes of Health's Ellen Leibenluft research group.[89] Mental health care providers diagnose this disorder based on symptoms, lifetime experiences, and sometimes, family history; it is essential to diagnose youth accurately.[90] For ministry leaders, this presents a challenge. Stephen Grcevic writes:

> I went through my caseload when I sat down to write this post. I realized that out of my family with a child actively being treated for bipolar disorder, **ONE** regularly participates in a local church's worship and ministry. It is more likely in our practice that a child with an autism spectrum disorder will be involved with the church than a family of a child with bipolar disorder.[91] Individuals with bipolar disorder may miss out on opportunities to serve others through the church. Leaders may express concern that they cannot be depended upon to follow through on commitments. The bottom line is that a group of young adults with a critically acute need for parents equipped to be their primary faith trainers are among the least likely to have a connection with a church prepared to provide and resource their parent(s) for the task.[92]

The stigma of mental illness has no place in the modern world, yet somehow, it remains. It is not unreasonable for ministry leaders to pray for God to eliminate the bipolar disorder. After all, the apostle Paul prayed three times for the Lord to remove his "thorn in the flesh" (cf. 2 Corinthians 12:7-9). However, God did not remove Paul's thorn, so people need not be

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[88] "Bipolar Disorder in Young People," *Australian Psychological Society* 34, (February, 2012), https://psychology.org.au/for-members/publications/inpsych/2012/feb/04-bipolar-disorder-in-young-people.

[89] Australian Psychological Society, "Bipolar Disorder in Young People," 34, (February, 2012), https://psychology.org.au/for-members/publications/inpsych/2012/feb/04-bipolar-disorder-in-young-people.

[90] "Bipolar Disorder," accessed Mar 18, 2023, https://www.nimh.nih.gov/health/topics/bipolar-disorder.

[91] Stephen Grcevich, "How Might Bipolar Disorder Affect Church Participation and Spiritual Development?" Church4EveryChild, 2010, https://church4everychild.org/2010/08/18/how-might-bipolar-disorder-affect-church-participation-and-spiritual-development–2/.

[92] Ibid.

disappointed if He declines the request.[93] Therefore, those in leadership positions must confidently navigate any situation, knowing God is in control and has already given them all the tools they need to do the job from a spiritual and medical standpoint.

Churches today are not properly equipped to help minister to adolescents and young adults with bipolar disorder. Author Vanessa Bhimanprommachak states that when a crisis strikes, people respond instinctively, but those initial impulses may not be incredibly productive or counterproductive. Unresolved situations will likely become disasters, and ministry leaders must act quickly. The key is communicating, leading compassionately, and managing the "new normal" after crises.[94] Failure to do so exposes churches, their ministry leaders, and families to scrutiny. The Scripture used around this intervention comes from 2 Timothy 1:8–14:

> Therefore do not be ashamed of the testimony about our Lord, nor of me, his prisoner, but share in suffering for the gospel by the power of God, who saved us and called us to a holy calling, not because of our works but because of his own purpose and grace, which he gave us in Christ Jesus before the ages began, and which now has been manifested through the appearing of our Savior Christ Jesus, who abolished death and brought life and immortality to light through the gospel, for which I was appointed a preacher and apostle and teacher, which is why I suffer as I do. But I am not ashamed, for I know whom I have believed, and I am convinced He can guard what has been entrusted to me until that day. Follow the pattern of the sound words you have heard from me: the faith and love in Christ Jesus. By the Holy Spirit who dwells within us, guard the good deposit entrusted to you (English Standard Version).

Michael Jones points out that biblical principles demonstrate how the church's calling is to teach and not walk away from individuals' mental health disabilities but to be there to assist them. A significant part of Jesus' earthly ministry is teaching (διδάσκω, *didaskō*) both the disciples and the crowds. "Teaching" (διδαχή, *didachē*) or "instruction" (παιδεία, *paideia*) is the

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[93] Kate Foley, "Ministry and Bipolar Behavior: Finding Hope in Christian Counseling," (April 30, 2021), https://millcreekchristiancounseling.com/ministry-and-bipolar-behavior-finding-hope-in-christian-counseling/.

[94] Vanessa Bhimanprommachak, "Leading Your Team Through a Crisis," (July 20, 2020), https://www.harvardbusiness.org/leading-your-team-through-a-crisis/.

handing down by the church of the doctrine handed down from Christ through His apostles. One designated as a teacher (διδάσκαλος, *didaskalos*; e.g., Eph 4:11; 2 Tim 1:11) helps God's people learn in a practical way (μανθάνω, *manthanō*).[95] According to Mary Rooney, teaching different treatment methods to help with bipolar disorder can be brought into practice through the following:

> Medication is not the only option, although it is an essential component of treatment for most people with bipolar disorder. Psychosocial or talk therapy [inaudible] is also potent for bipolar disorder. So different kinds of psychosocial therapy can help children, teens, young adults, and their families manage the symptoms. Therapies that are based on scientific research or what we would call evidence-based treatments include cognitive-behavioral approaches and family-focused therapy. These treatments provide support, education, and guidance to teens, young adults, and their families. In each of these treatments, family involvement is a critical component. These therapies teach skills that can help people manage bipolar disorder, including skills for maintaining routines, enhancing emotional regulation, and improving social interactions. Improving family communication and functioning can also be essential to these treatments. With treatment, children and teens, and young adults with bipolar disorder can get better over time. Treatment is most effective when healthcare providers, parents, and young people work together. [96]

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM–5), this bipolar "sickness" should fall into the category of a depressed mood, a mixed mood, a manic mood, or a hypomanic mood for those with bipolar disorder. These moods have a variety of symptoms relating to emotional and physical health.[97] In her blog, Natasa Tracy writes that when she is bipolar-sick, she may experience any feeling of her bipolar or the complications that

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[95] Michael R. Jones, "Teaching," *Lexham Theological Wordbook*, ed. Douglas Mangum et al., (Bellingham, WA: Lexham Press, 2014).

[96] "NIMH Expert Mary Rooney Discusses Bipolar Disorder in Adolescents and Young Adults," accessed Mar 20, 2023, https://www.nimh.nih.gov/news/media/2021/nimh-expert-dr-mary-rooney-discusses-bipolar-disorder-in-adolescents-and-young-adults.

[97] "Supplement to Diagnostic and Statistical Manual of Mental Disorders (DSM–5) Update," (October, 2018), https://psychiatryonline.org/pb-assets/dsm/update/DSM5Update_October2018.pdf.

causes her to suffer and feel unwell.[98] Chris Byrley's wordbook describes the term sickness from the Old Testament (OT) and New Testament (NT):

> In the Old Testament, sickness is more than a mere bodily affliction. The Hebrew terms חָלָה (*ḥālâ*, "to be sick") and חֳלִי (*ḥŏlî*, "sickness") relate to weakness and, therefore, a lack of wholeness. A person does not need merely to be healed of sickness but to be revived and restored (2 Kgs 1:2; Isa 38:1). Isaiah, therefore, speaks of the Suffering Servant as one who bears our "griefs" (*ḥŏlî*), alluding to Jesus' provision of salvation from our sins. In addition, sickness and disability could make a person ritually impure. Someone infected with leprosy (צָרַעַת, *ṣāraʿat*) or another skin disease was not permitted to remain in society but was forced to live as an outcast (Lev 13:45–46). Further, Levites suffering from an illness or disability could not carry out priestly duties (Lev 21:18).[99]
>
> The New Testament speaks in similar terms regarding the nature of sickness. Like Hebrew, the most common Greek words, ἀσθενέω (*astheneō*, "to be sick") and its related forms, can also be used to indicate weakness. Sickness and especially leprosy continue to cause people to be treated as outcasts in the NT. Still, the Gospels present Jesus as one who crosses the traditional boundaries to extend healing and cleansing to all people. Thus, when a man meets Jesus with leprosy (λεπρός, *lepros*), He not only heals him but touches him (Mark 1:40–41). Whereas the writers of the OT recognized that sickness was a symptom of man's weakness and looked to God for healing, Jesus provided that healing to all who came to him in his public ministry. Furthermore, 1 Peter explicitly portrays salvation as healing when he quotes Isa 53:5: "by whose wounds (μώλωψ, *mōlōps*) you have been healed (ἰάομαι, *iaomai*)" (1 Pet 2:24).[100]

Families affected by bipolar disorder need special assistance from their ministry leaders and ongoing spiritual support for the affected individuals with bipolar disorder. Still, the church's role is to have a plan or program to have educated ministry leaders do so. While mental illness can be challenging to discuss in churches, they need to have members who are spiritually, physically, and mentally healthy as well. The researcher will create an educational program to help ministry leaders to create a spiritual, emotional, and cognitively stimulating environment for church members.

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[98] Natasha Tracy, "Bipolar - What Does 'I'M Sick' Mean?" accessed Mar 20, 2023, https://natashatracy.com/bipolar-blog/bipolar-what-im-sick-mean/.

[99] Chris Byrley, "Sickness and Disability," *Lexham Theological Wordbook*, ed. Douglas Mangum et al., (Bellingham, WA: Lexham Press, 2014).

[100] Byrley, "Sickness and Disability."

Theoretical Foundations

The integration of social support into psychotherapy and pharmacological interventions can improve mental well-being among patients, according to psychology and healthcare experts. There are several perspectives on how social support affects mental health. Still, their details and views differ regarding its potential to improve well-being among an individual with bipolar disorder. Ministry leaders need education on how to create a network of social support which promotes healing and improved well-being for individuals with bipolar disorder. This theoretical foundation section addresses this need.

After reviewing recent research on the influence and importance of social support on mental health problems, some critical theoretical perspectives and foundations follow. These perspectives and foundations set the scientific domain within the project's thesis context. [101] However, that is not to say that different theoretical approaches are invalid. The views adopted and described in this section are the most relevant and valuable to the particular focus, aim, and purpose of this thesis and are the ones that help provide a scientific justification for the current study and the intended findings.

Social support theory is the over-arching theoretical framework for positioning this thesis within the scientific domain. The social support theory emerged from the published works by Francis Cullen and Don Drennon-Gala, who shared that informational, emotional, and instrumental social support is critical in reducing the likelihood of crime and delinquency among youths and young adults.[102] The theory relies on both the macro and micro-level effects of social

[101] Knut Ivar Bjørlykhaug et al., "Social Support and Recovery from Mental Health Problems: A Scoping Review," 2022, https://www.tandfonline.com/doi/epdf/10.1080/2156857X.2020.1868553?needAccess=true&role=button.

[102] Lisa Kort-Butler, *Social Support Theory* (John Wiley and Sons, 2018).

support. It emphasizes that supportive societies and relationships can lessen delinquency and the risk of developing mental health problems and deviant behaviors.[103] Research suggests that social support is crucial to the mental well-being of adolescents and young adults with bipolar disorders despite its primary application to social control and rehabilitation. The framework can guide interventions addressing bipolar disorder challenges for youth and young adults. Supportive societies and supportive relationships are the two perspectives advanced in the social support theory that helps link support to improve bipolar disorder. Supportive societies and supportive relationships define the social resources on which people can rely and depend when dealing with life challenges and stressors. Individuals with bipolar disorder who have supportive relationships receive support from family members, friends, and colleagues.

In contrast, supportive societies are macro-level factors that stem from the interaction between societies (communities and states) and their members. For example, formal entities such as governmental institutions can enhance supportive societies within a community or country by fairly and justly distributing national resources.[104] Both supportive societies and relationships provide support resources to societal members.

Social support has several dimensions, whether it originates at a micro-level or a macro-level, according to the social support theory. The first definition of support is the feeling the individual with bipolar disorder has of being supported or the assurance that support is available and accessible to them. Second, social support can be instrumental, informational, or emotional. Instrumental social support defines the availability of tangible resources and materials that can handle practical tasks or address a problem, such as lending money. Informational support

[103] Kort-Butler, Social Support Theory.

[104] Ibid.

establishes the availability of advice, guidance, and educational insight to help an individual with bipolar solve a problem. Lastly, emotional support expresses emotionality like empathy, care, encouragement, motivation, and sympathy.[105] Although these forms of social support are equally available at the macro- and micro-level, their influence largely depends on the source.

How individuals overcome problems like bipolar disorder challenges depends on where they derive social support. Members of an individual with bipolar disorders primary group, including family members and friends, are the frequent and critical sources of social support.[106] For example, in their study investigating the interaction between family and psychosocial functioning in bipolar disorder, Dou et al., found that bipolar disorder patients living in families providing social support reported improved psychosocial well-being and resilience and reduced suicidal ideation.[107] An individual with bipolar disorders may also draw support from secondary sources, including schools and religious organizations like the church.[108] However, although the primary and secondary sources of support are essential, the former ranks high in the hierarchy and is more effective and readily available than the latter.

Variation in the availability of social support within an individual's environment affects how they address problems and deal with mental health problems. The availability of social support varies depending on an individual's structural condition and social setting. Social setting and location determine the amount and quality of functional relationships and resources an individual can rely on for social support. The community in which an individual lives contributes scarce resources to support its members, which directly affects a person's access to social

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[105] Kort-Butler, Social Support Theory.

[106] Ibid.

[107] Wenbo Dou et al., "Family and Psychosocial Functioning in Bipolar Disorder: The Mediating Effects of Social Support, Resilience and Suicidal Ideation," *Frontiers in Psychology* 12 (2022): 6632.

[108] Kort-Butler, Social Support Theory.

support to address mental health challenges.[109] These variations define the differences in how individuals in different social settings handle and deal with mental health problems. Persons within supportive communities who can easily access social support from primary and secondary sources have limited challenges coping with mental health problems.

While social support from primary sources is valuable in helping individuals overcome bipolar disorder problems, it is not always available due to people's reluctance to seek assistance. Family support determines how individuals with mental health problems, especially bipolar disorder, and psychosis, overcome such challenges to live healthy and productive lives. However, while family and community support for people experiencing mental health problems like bipolar disorder relieves considerable strain on national healthcare resources and contributes to improved well-being among the affected persons, these gains are achieved at a significant personal cost. Providers for people with psychosis or bipolar disorder frequently report high cases of distress, limited access to social resources, financial burden, and suicidal thoughts.[110] As a result, most people may shy away from taking care of individuals with bipolar disorder or psychosis to avoid the involved consequences. Even if they agree, they may end up experiencing mental health problems increasing the burden on the community.

Equally, at the national level, social support may be unavailable, especially when the government fails to dedicate sufficient resources, including funds, to promote mental health in the population. Social support incorporates instrumental support that defines material resources individuals can leverage to overcome mental health problems.[111] However, governments have

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[109] Kort-Butler, Social Support Theory.

[110] Marshall et al. "Caring for a Family Member with Psychosis or Bipolar Disorder Who Has Experienced Suicidal Behaviour: An Exploratory Qualitative Study of an Online Peer-Support Forum," 15192.

[111] Kort-Butler, Social Support Theory.

limited national resources in specific contexts, especially in low- and medium-income countries. They cannot effectively provide quality, affordable, and accessible mental health care for their populations. For example, while nearly 50% of all persons living with bipolar disability worldwide live in low-income and lower-middle-income countries, only as few as 10% of these individuals with mental health problems access care.[112] These deficits justify the need for improved interventions to change how individuals with mental health problems like bipolar disorder can access social support.

Empowering churches, communities, and families can improve the amount and quality of social support available for individuals with bipolar disorder problems. Family members, community members, including friends, and ministry leaders are individuals' primary sources of social support. Using a study of schizophrenic patients' families' psychological training programs, Sogutlu et al. Researchers found that psychological training programs for family members of schizophrenic patients helped them adapt to the problem as caregivers by changing their perspective on mental health.[113] Family members who participated in the psychological training programs reported improved caring attitudes and ability to attend to the needs of their schizophrenic patients without getting tired or affected by their relative's mental health problems. Although the study focused on schizophrenia, the findings are generalizable and demonstrate that training and empowerment can improve the social support available for mentally ill patients from their family members.

[112] C. J. Arnbjerg et al., "Intervention Trials for Adults with Bipolar Disorder in Low-Income and Lower-Middle-Income Countries: A Systematic Review," *Journal of Affective Disorders*, 311, (2022).

[113] Lutiye Sogutlu et al., "The Effectiveness of Family Psychological Training Program Applied to Relatives of Patients with Schizophrenia," *Psychiatria Danubina* 33, no. 4 (2021): 551–59.

Religious organizations, including the church, can actively provide social support to individuals with bipolar disorder problems in situations where the government is limited. While developing the social support theory, Cullen observed that most studies on macro-level social support focus on measures involving government expenditure while neglecting the role of private and charitable organizations. In their theory, Cullen outlined that private and philanthropic organizations, including religious entities like the church, are vital sources of social support that can help individuals overcome mental health problems. Therefore, the church can play an essential role in providing an educational program for leaders confronting the problem of adolescents and young adults with bipolar disorder based on adequate theoretical foundations.

Conclusion

Bipolar disorder is a major mental health problem causing a significant burden on societies, families, and individuals. Globally, bipolar disorder is a leading cause of disability and loss of productivity among adolescents and young adults. However, despite this bipolar disorder problem threat in societies, these individuals with bipolar disorder are reluctant to seek help. Additionally, while specific youths with bipolar disorder may seek help, inadequate resources in cultures and communities limit individuals' access to treatment and support. As a result, the lack of support and therapy exposes these individuals with mental health problems to immeasurable long-term suffering. Bipolar disorder is a cross-cutting issue that affects the church equally as much as society.

The church is an institution that has long tried to address mental health problems in societies and is responsible for managing bipolar disorder. The church is among the earliest institutions to provide formalized help to individuals suffering from mental health problems. However, today, limited resources have hindered the ministry leaders and limited their

participation in addressing bipolar disorder problems in societies. As a result, the burden of caring for bipolar individuals has shifted to informal care settings involving family-based care. While family-based care provides an alternative intervention for maintaining bipolar individuals and reduces the strain on national healthcare resources, the gains are at high personal costs. Families experience considerable challenges caring for relatives with bipolar disorder, mainly due to a lack of support. Despite limited resources, the church can support its ministry leaders of individuals with bipolar disorder by providing non-financial interventions to improve the lives of adolescents and young adults who have this bipolar disorder.

CHAPTER 3: METHODOLOGY

The proposed project will implement a Ministry Leaders Educational Plan to assist ministry leaders with recognizing possible bipolar disorder signs in adolescents and young adults. The project will employ qualitative and quantitative techniques to generate, analyze, and assess data to elucidate if the project will lead to a better understanding of ministry leadership guidance.[1] This chapter describes the methodology used for this blend of data-gathering methods that allows for statistically evaluating changes to a leader's abilities after the educational program's completion. This chapter describes the project design, data collection, and results analysis.

Intervention

This project aims to assess the specific needs of an educational program to help assist ministry leaders with various evidence-based research and biblical foundations while ministering to adolescents and young adults with bipolar disorder. A mixed methodology was most appropriate to identify the leadership roles presented by ministry leaders in this project. The researcher conducted pre- and post-test surveys to determine ministry leaders' perspectives. The survey's instrument provided a quantitative data analysis to formulate conclusions regarding the leadership needs of ministry leaders and individuals with bipolar disorder.[2] The researcher will then attempt to contact twenty ministry leaders from the project for interviews. Twenty ministry

[1] Tim Sensing, Qualitative Research: A Multi-Methods Approach to Projects for Doctor of Ministry Theses (Eugene, OR: Wipf & Stock, 2011), 52.

[2] Ibid., 115.

leaders will participate in the focus group, and the interview results will be used to collect qualitative data. Transcripts of the interviewee's responses will be transcribed and analyzed individually for a more detailed understanding of their opinions and feelings.[3]

Intervention Design

This project assesses the specific needs and desires of the target population in order to gather the information that can help ministry leaders tailor efforts for ministering, understanding, and recognizing bipolar disorder in adolescents and young adults, as well as how to create an environment that is accepting and healthy for young people with bipolar disorder. The project will use interpretative research design. Qualitative and interpretive research are different concepts, but the terms are often interchangeable. An interpretive research paradigm assumes that social reality is not a singular, objective reality but a collection of human experiences and settings (ontology).[4] The most effective way to study it is to reconcile the subjective interpretations of its various participants (epistemology) within its historical context.[5]

As the founder of modern research surveys, Paul Felix Lazarsfeld contributed considerably to statistical survey analysis, panel methods, latent structure analysis, and contextual analysis.[6] Several positivist techniques failed to provide exciting insights or new knowledge, resulting in a resurgence of interest in interpretive research since the 1970s. Interpretive inferences can only occur when strict criteria and exact methodologies are

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[3] Tim Sensing, *Qualitative Research,* 102.

[4] Anol Bhattacherjee, "Interpretive Research," in *Social Science Research: Principles, Methods and Practices* (Revised Edition), 2019, https://usq.pressbooks.pub/socialscienceresearch/chapter/chapter–12-interpretive-research/.

[5] Ibid.

[6] Paul Felix Lazarsfeld: Father of Research Surveys, Sogolytics Blog. 2012, https://www.sogolytics.com/blog/paul-felix-lazarsfeld-the-father-of-research-surveys/.

employed.[7] Using the church setting as an opportunity to minister to bipolar adolescents and young adults, this project aims to maximize minister leaders' leadership and ministerial skills.

The purpose and objectives of the project is to address the problem and the lack of adequate resources to help ministry leaders minister to adolescents and young adults with bipolar disorders. The literature review did not identify any methods for doing this; therefore, ministry leaders will be taught evidence-based techniques to take positive action after implementing an eight-week Ministry Leaders' Intervention Education Plan.

Leaders of adolescents and young adults with bipolar disorder will gain actionable insights and practical strategies to avoid complexities linked to social isolation and stigma associated with these bipolar disorder individuals through the project. Interpretive research should attempt to collect qualitative and quantitative data about the phenomenon of interest, as should positivist research.[8] The researcher will conduct an eight-week educational plan and collect data after the intervention to evaluate the program's effectiveness. Ultimately, a mixed research method involves collecting data through surveys, interviews, and focus groups.

Sampling

The target population for this proposed interpretative research project will be ministry leaders ministering to adolescents and young adults aged 6–25, and older individuals with bipolar disorder attending the Love Faith Church in Columbia, SC. The purposeful sampling method involves selecting eight ministry leaders based on criteria to obtain a representative sample.[9] Ministry leader participants must be at least 18 years old and willing to participate in

[7] Bhattacherjee, "Interpretive Research."

[8] Ibid.

[9] Janice M Morse, "The Significance of Saturation," *Qualitative Health Research* 5, no. 2 (–05–01, 1995): 147–49, https://doi.org/10.1177/104973239500500201.

the eight-week educational program. The screening survey will include demographic information questions such as age, gender, location, and leadership roles to determine if the participant is eligible for this project (see Appendix E).

Data Collection

The proposed project will employ a mixed methods research approach to collect data regarding the efficacy of the Ministry Leaders Educational Program.[10] The primary method driving this study is quantitative, making this a QUAN-Qual study. In the initial phase, quantitative data will be collected through surveys to measure knowledge, communication, and leadership changes after the program. This data will provide a broad understanding of the program's impact and effectiveness. In the subsequent phase, qualitative data will be gathered through interviews and focus groups. This follow-up phase aims to delve deeper into specific areas identified in the initial quantitative phase, providing richer insights, and identifying areas for improvement. Data collection will continue until no new information or themes emerge from either the quantitative or qualitative data.[11] This QUAN-Qual approach ensures a comprehensive assessment of the Ministry Leaders Educational Program.

Data Analysis

To better understand the needs of ministry leaders, the researcher will attempt to create a frequency chart to determine which questions scored the lowest and highest. The researcher will collect the quantitative from the surveys and transcribe them from words to numbers. By doing so, the researcher can use statistical analysis to answer the research questions. Additionally, the

[10] Sensing, Qualitative Research, 52.

[11] Ibid., 139.

researcher will conduct interviews to collect qualitative data. The researcher will analyze transcriptions and responses to understand interviewee opinions better. The descriptive statistics will also include averages and variability. Graphs, scatter plots, and frequency tables will also be necessary to visualize and analyze the data.[12] The researcher's choices will form the basis for reporting the results from these categories.

Implementation of the Intervention Design

Liberty University's Institutional Review Board had first approved the research project design in the ministry setting. Additionally, the researcher had completed the Collaborative Institutional Training Initiative training to apply for Institutional Review Board approval. During research conducted by Liberty University faculty, staff, or researchers, the Institutional Review Board (IRB) had protected the rights and welfare of participants. Liberty University's DMIN Program and Thesis Project Manual contained this statement. Research involving people or information about people required approval by the IRB before any enrollment of participants or collection of data for the project. As one method of protecting participants' rights and welfare, the IRB followed this procedure. Following approval, the researcher had proceeded with the next step in the research process.[13] Each eligible participant had received detailed information about the program during the orientation session and was issued consent forms. Participants were allowed to participate in the program only after they had understood the project's objective and how it might impact them.

[12] Sensing, Qualitative Research, 196.

[13] "Institutional Review Board | Institutional Review Board | Liberty University," accessed Mar 19, 2023, https://www.liberty.edu/graduate/institutional-review-board/.

Obtaining approval from the pastor to conduct a project in the church (see Appendix A) and gaining permission from the pastor (see Appendix B) was an IRB requirement, and it allowed the pastor to approve or disapprove the project in their church setting.[14] Informed consent forms (see Appendix C) contained information regarding the researcher, the task, the reason for the request, all aspects of the project, its objectives, activities, rewards, risks, and rights of those involved. Only the researcher knew who took part and how they responded, and the researcher used pseudonyms to protect their identities to maintain confidentiality (see Appendix D).[15]

The researcher had outlined data collection implementation to this interpretive research design consisting of surveys (see Appendix F), interviews (see Appendix G), and focus groups (see Appendix H) of open-ended questions. Each stage of the training concluded with an assessment to measure progress made and ended with a brief debrief session (see Appendix I).[16] This program introduced participants to bipolar disorder, biblical figures who dealt with mental illness, behavioral, cognitive, and emotional challenges associated with bipolar disorder, and different strategies for providing short-term support (see Appendix J).

Approximately seven days before the project began, the researcher emailed each ministry leader participant their pre-test survey questions. For ministry leaders to continue participating, they had to return pre-test surveys within ten days. Each ministry leader began the interview process once interview times were confirmed. After each ministry leader confirmed the date, the group received an email reminder to attend a Zoom meeting to record questions and answers from focus groups. During sessions, responses were recorded, and participants were polled by

[14] "Institutional Review Board."

[15] Ibid.

[16] Sensing, Qualitative Research, 127.

the researcher. The project strived to be effective and time-efficient for personnel involved and generated timely feedback. All ministry leaders who completed the educational program received a digital $10.00 Amazon gift card as a thank-you from the researcher. The researcher used this strategy because it allowed people to reshape their behavior and actions by reimagining ways of seeing things, not merely by rationalizing solutions to problems.

CHAPTER 4: RESULTS

Introduction

In pursuit of addressing the needs of adolescents and young adults with bipolar disorder within the context of a faith community, this study embarked on a comprehensive examination. The study aimed to equip ministry leaders with the knowledge, tools, and strategies necessary to navigate the challenges associated with bipolar disorder. The overarching hypothesis of this research posited that implementing an eight-week Ministry Leaders' Intervention Education Plan would enhance ministry leaders' understanding and capacity to support these young individuals effectively. To unravel the intricate landscape of ministry leaders' perspectives, experiences, and attitudes toward bipolar disorder in adolescents and young adults, a mixed-methods approach was employed. This approach integrated both quantitative and qualitative data analyses, aided by SPSS and NVIVO software, respectively to provide a holistic understanding of the phenomenon.

Originally, the plan was to contact twenty ministry leaders from the project for interviews, and have them participate in the focus group. However, due to unforeseen circumstances, only eight ministry leaders were able to participate. Despite this, the smaller group size did not diminish the quality of the data collected. In fact, it allowed for a more in-depth exploration of each participant's experiences and perspectives. In this chapter, the researcher systematically organized and presented the quantitative data to provide a comprehensive picture of ministry leaders' perspectives and the potential impact of the Ministry Leaders' Intervention Education Plan. Subsequently, the researcher presented the results of this

study with an exploration of the qualitative findings before concluding with a summary of the results. The qualitative data, though collected from a smaller group than initially planned, offers valuable insights into the lived experiences of ministry leaders dealing with bipolar disorder in adolescents and young adults. These insights are crucial for understanding the phenomenon and informing the development of effective intervention strategies.

Results

Quantitative Findings

Regarding quantitative data, the Pre-Test Questions were structured with multiple-choice options A, B, C, D, or E. In this case, “A,” “B,” and “C” corresponded to the correct answers, while D was included as an incorrect but plausible option. Option “E” was designated for respondents without knowledge to answer the question, signifying “I do not know.” Conversely, the Post-Test Questions utilized a 5-point Likert scale for responses, where option “A” represented “Strongly Agree,” and option “E” signified “Strongly Disagree.” This scale allowed participants to express their degree of agreement or disagreement with statements related to the educational program’s effectiveness and their understanding of bipolar disorder.

Age Distribution

Participants’ demographics show that 50% of the respondents were between 31 to 40 years followed by those aged between 20 and 30 (37.50%) and the remaining (12.50%) being 41 to 50 (see figure 1).

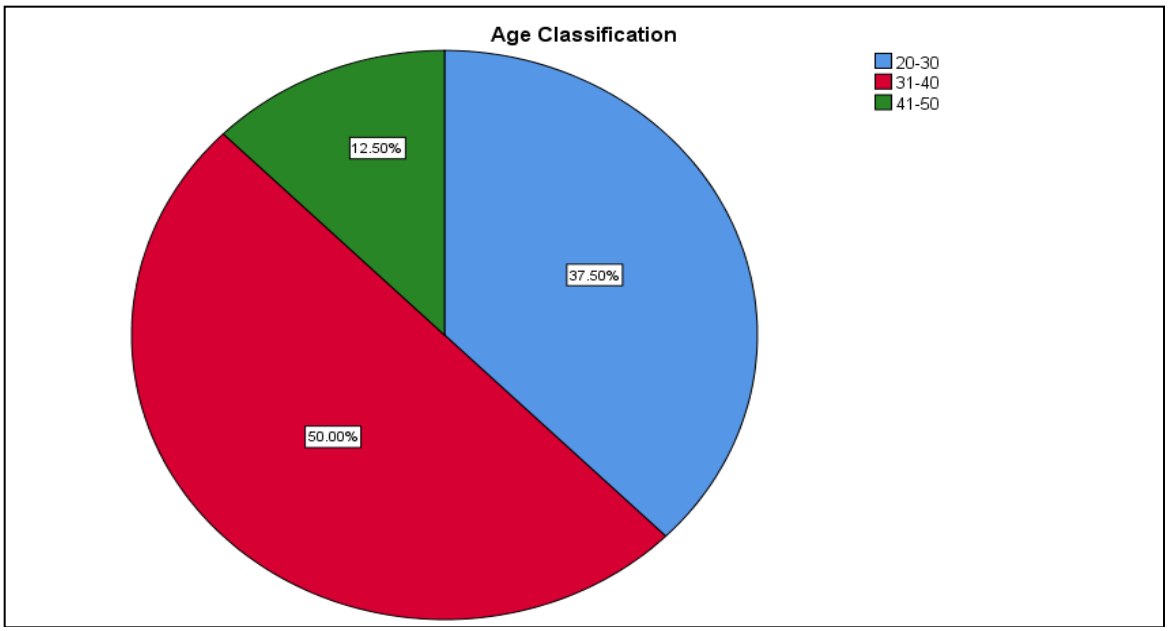

Figure 1. Age classification

Gender Distribution

The respondents were evenly distributed with four males (50%) and four females (50%) as indicated in figure 2.

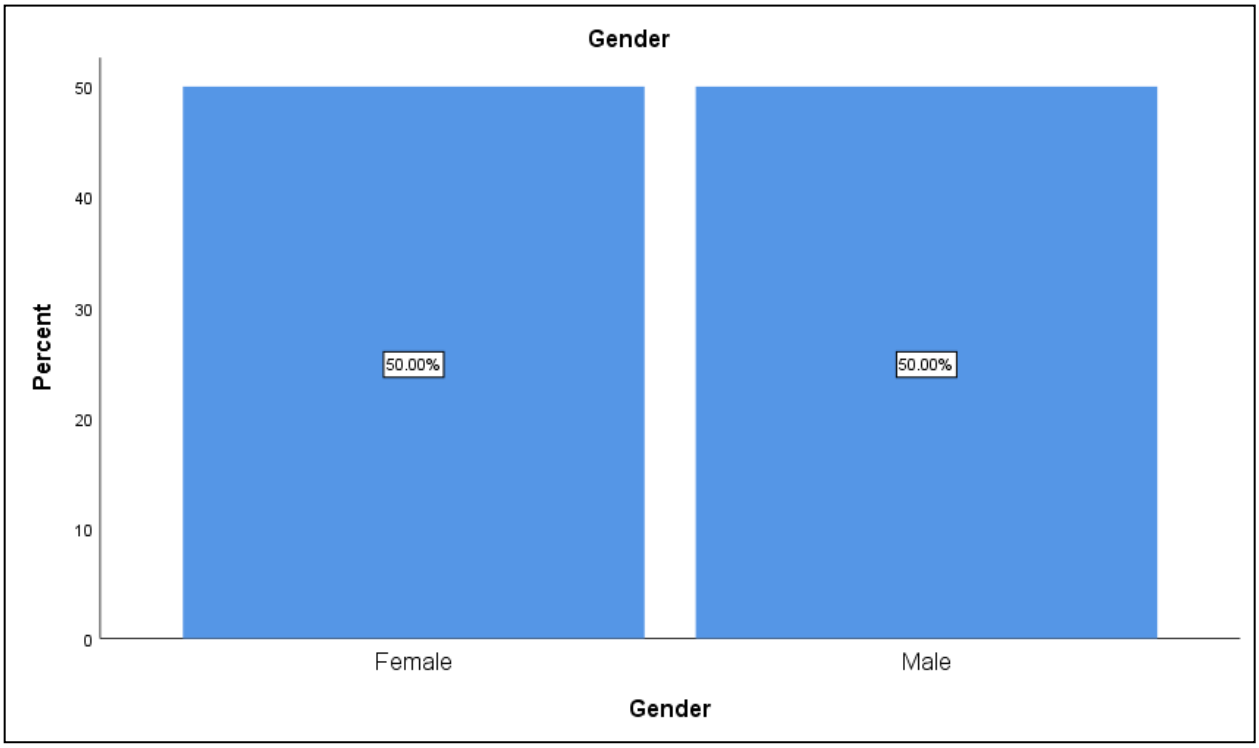

Figure 2. Gender

Leadership Roles

Regarding the leadership roles of the participants, two (25%) were youth leaders, two (25%) were worship leaders, two (25%) were pastors and two (25%) had counselor roles (see figure 3).

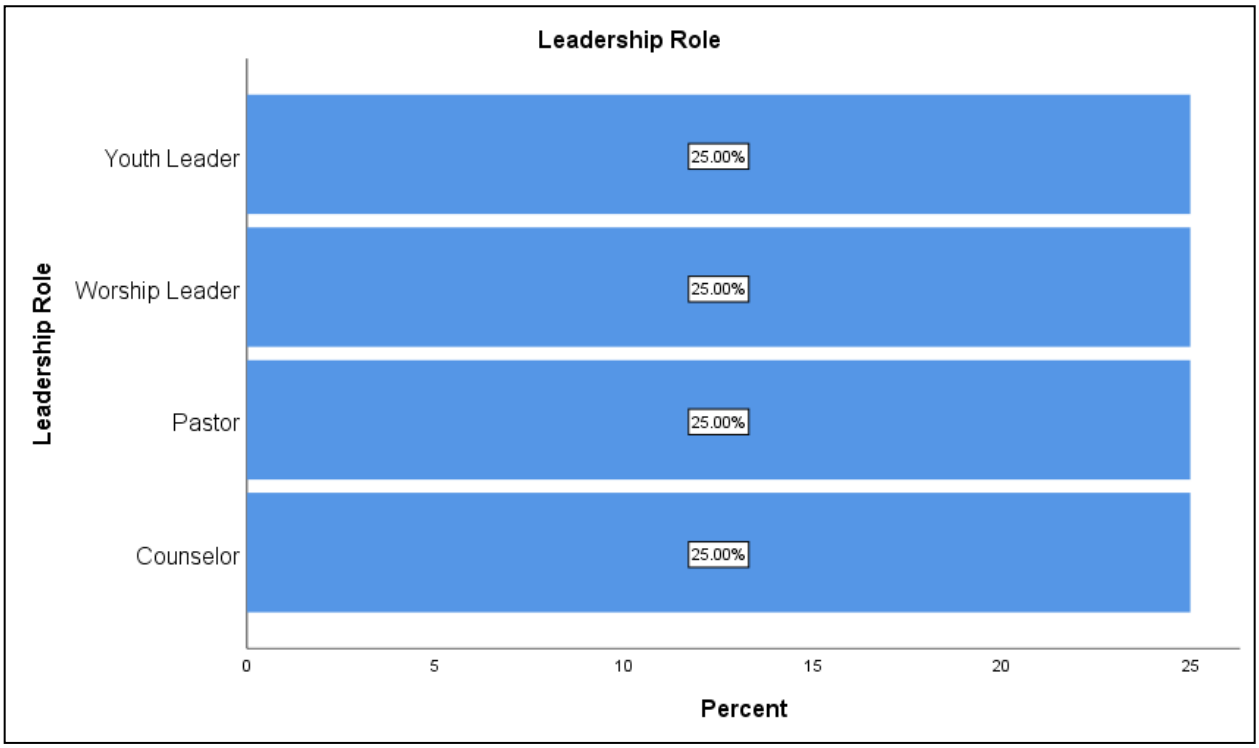

Figure 3. Leadership role

Paired Samples T-Test

A paired samples t-test was conducted to evaluate the impact of the educational program on participants' understanding of bipolar disorder and related topics. The pretest and posttest served different purposes, with the pretest designed to assess baseline knowledge about bipolar disorder and the posttest intended to evaluate the effectiveness of the educational program. Therefore, it was necessary to use different types of questions.

Despite the different question types, the constructs being measured (knowledge about bipolar disorder and effectiveness of the educational program) were closely related. The

educational program presumably aimed to increase knowledge about bipolar disorder, so it makes sense to measure these constructs. The paired samples t-test was an appropriate method to analyze the data, as it can handle different types of data and is robust to differences in question types.

A paired samples t-test was conducted to assess the significance of differences between pretest and posttest responses for eight survey questions. The results revealed statistically significant differences across all paired comparisons (see table 1). For PretestQ1 and PosttestQ1, which evaluated the understanding of bipolar disorder, the mean difference was –2.875 (Std. Deviation = 1.126), $t(7) = –7.222$, $p < .001$. This indicates that the educational program had a substantial positive impact on participants' skill levels when leading individuals with bipolar disorder.

Similarly, PretestQ2 and PosttestQ2, assessing the recognition of bipolar disorder symptoms, showed a mean difference of –2.500 (Std. Deviation = 0.926), $t(7) = –7.638$, $p < .001$, indicating a significant improvement in participants' ability to identify bipolar disorder symptoms. PretestQ3 and PosttestQ3, which examined church stigmas surrounding bipolar disorder, exhibited a mean difference of –3.125 (Std. Deviation = 1.126), $t(7) = –7.850$, $p < .001$. This reflects a substantial reduction in the perception of stigmas following the educational program.

Regarding PretestQ4 and PosttestQ4, focusing on the types of bipolar disorders, the mean difference was –2.250 (Std. Deviation = 1.035), $t(7) = –6.148$, $p < .001$, indicating improved knowledge about the different types of bipolar disorders. PretestQ5 and PosttestQ5, evaluating biblical perspectives on special needs, displayed a mean difference of –1.375 (Std. Deviation =

0.518), t(7) = –7.514, p < .001, indicating that participants were better able to identify relevant biblical principles.

For PretestQ6 and PosttestQ6, exploring sensory overload examples, the mean difference was –2.250 (Std. Deviation = 1.165), t(7) = –5.463, p = .001, demonstrating enhanced understanding of sensory overload following the program. PretestQ7 and PosttestQ7, which addressed leadership alert measures, exhibited a mean difference of –2.125 (Std. Deviation = 0.835), t(7) = –7.202, p < .001, indicating improved comprehension of leadership alert measures.

In addition, PretestQ8 and PosttestQ8, focusing on a leader's self-aid coping care skills, displayed a mean difference of –2.750 (Std. Deviation = 1.165), t(7) = –6.677, p < .001, reflecting increased awareness of self-aid coping care skills. Overall, these results indicate that the educational program significantly enhanced participants' knowledge and understanding of bipolar disorder and related topics, supporting the hypothesis that the program would lead to a better understanding of ministry leadership guidance in addressing bipolar disorder within the church setting.

Table 1. Paired samples t-tests

		Paired Differences							
					95% Confidence Interval of the Difference				
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper	t	df	Sig. (2-tailed)
Pair 1	PretestQ1 What is bipolar disorder? - PosttestQ1 This Educational Program improved participants' skill levels when leading adolescents with bipolar disorder and young adults with bipolar disorder.	–2.875	1.126	.398	–3.816	–1.934	–7.222	7	.000

Pair 2	PretestQ2 What are some symptoms of bipolar disorder? - PosttestQ2 This Educational Program identified bipolar disorder symptoms.	–2.500	.926	.327	–3.274	–1.726	–7.638	7	.000
Pair 3	PretestQ3 What are some church stigmas surrounding bipolar disorder? - PosttestQ3 This Educational Program reviewed some church stigmas surrounding bipolar disorder.	–3.125	1.126	.398	–4.066	–2.184	–7.850	7	.000
Pair 4	PretestQ4 How many types of bipolar disorders are there? - PosttestQ4 This Educational Program discussed four types of bipolar disorders.	–2.250	1.035	.366	–3.115	–1.385	–6.148	7	.000
Pair 5	PretestQ5 Who are some biblical figures that can give biblical perspectives about special needs? - PosttestQ5 This Educational Program helped the participants identify biblical principles that give perspectives on special needs.	–1.375	.518	.183	–1.808	-.942	–7.514	7	.000
Pair 6	PretestQ6 What are some examples of sensory overload? - PosttestQ6 This Educational Program gives some examples of sensory overload to participants.	–2.250	1.165	.412	–3.224	–1.276	–5.463	7	.001

Pair 7	PretestQ7 What are some examples of leadership alert measures with individuals? - PosttestQ7 This Educational Program improved the participant's understanding of leadership alert measures.	–2.125	.835	.295	–2.823	–1.427	–7.202	7	.000
Pair 8	PretestQ8 What are some examples of a leader's self-aid coping care skills? - PosttestQ8 This Educational Program brings awareness to a leader's self-aid coping care skills.	–2.750	1.165	.412	–3.724	–1.776	–6.677	7	.000

Qualitative Findings

The researcher meticulously employed the Braun and Clarke procedure, a well-structured and systematic approach to analyze the responses obtained in this study qualitatively. This rigorous process entailed several distinct steps to extract meaningful insights from the data. First, the interview questions were methodically coded, each one assigned a specific code label ranging from IQ1 to IQ15, while the focus group questions received their designated codes, denoted as FQ1 to FQ8. This meticulous coding allowed for the systematic organization of the qualitative data, ensuring that each response could be easily tracked and retrieved during the analysis.

Following the coding process, the researcher delved into a thorough and exhaustive categorization exercise. Responses were systematically grouped into related categories based on their content and context. This meticulous categorization ensured that similar ideas and concepts were aggregated together, laying the groundwork for the identification of broader patterns within the data. As the analysis progressed, the researcher engaged in a meticulous examination of these categorized responses, scrutinizing them for recurring themes and meaningful connections.

Through this iterative process of careful review and reflection, six overarching themes began to emerge organically from the data.

Within the overarching themes, corresponding subthemes were identified, providing a more granular understanding of the multifaceted perspectives and experiences of the ministry leaders involved in this study. These subthemes added depth and nuance to the analysis, enriching our comprehension of the complexities surrounding bipolar disorder within the context of a faith community. The Braun and Clarke procedure served as the guiding framework for the systematic analysis of qualitative data in this research. It facilitated the organization, categorization, and discovery of overarching themes and subthemes, ultimately contributing to a comprehensive and insightful exploration of ministry leaders' perspectives and experiences.

Theme 1: Understanding and Awareness of Bipolar Disorder

The first theme, "Understanding and Awareness of Bipolar Disorder," reflects participants' initial knowledge and perceptions regarding bipolar disorder in adolescents and young adults within a faith community. This theme encompasses two subthemes highlighting the journey from limited understanding to a profound desire for education and awareness.

Subtheme 1.1: Lack of Initial Understanding

Participants openly shared their initial lack of understanding regarding bipolar disorder, revealing a dearth of awareness and knowledge surrounding it. This initial unfamiliarity often led to misconceptions and posed challenges in addressing bipolar disorder within their ministry roles. Participant 1 (Pastor - Interview) admitted to his prior ignorance and said,

> Honesty, I didn't really know what bipolar disorder was before I joined this educational program. It was just a term for me, something I'd heard but never really understood. I had no idea about the symptoms or how it affects young people. This lack of knowledge left me feeling ill-equipped to provide the support and guidance that these adolescents and

> young adults truly needed. However, as I engaged with the program, listened to the experiences of those affected, and learned from our discussions, my understanding evolved. I realized the importance of becoming informed and empathetic, not just as a ministry leader but as a human being, to offer meaningful assistance and create an inclusive and supportive faith community for everyone, regardless of their mental health challenges.

Similarly, Participant 2 (Youth Leader - Focus Group) articulated,

> When I started as a youth leader, I didn't have a clue about bipolar disorder. It was like this mysterious thing, and I wasn't sure how to approach it. I felt a bit lost, to be honest. But being a part of this educational program has been an eye-opener. I've gained insights into what bipolar disorder really is, the signs to look out for, and how it can impact young people in our church community. It is been an enlightening journey, and I now feel better equipped to provide support and understanding to those who may be struggling. This knowledge has not only enriched my role as a youth leader but has also deepened my connection with our youth members, allowing me to create a more compassionate and inclusive environment for them.

Participant 4 (Counselor - Interview) acknowledged that even as a counselor, there were gaps in their knowledge. They shared,

> Even as a counselor, I've encountered situations where I had to educate myself more about bipolar disorder because it is not something people learn about in-depth during our training. The reality is that mental health is a vast field with various disorders, and bipolar disorder is just one facet of it. However, through my experience and engagement with this educational program, I've come to appreciate the importance of continuous learning and staying updated in my profession. It highlighted the need for ongoing education, especially in areas like bipolar disorder, where understanding the nuances can make a significant difference in providing effective support. This journey has reaffirmed my commitment to helping individuals with bipolar disorder and underscored the importance of expanding our knowledge base in the mental health field to better serve our clients.

Subtheme 1.2: Desire for Education

Conversely, the second subtheme underscores the participants' fervent desire to acquire knowledge and education about bipolar disorder. They recognized the vital importance of enhancing their understanding to effectively support and minister to adolescents and young adults grappling with bipolar disorder. Participant 3 (Worship Leader - Focus Group) shared how their proactive pursuit of knowledge evolved by revealing,

> Once I realized how little I knew about bipolar disorder, I actively sought out resources and educational materials. I wanted to be better equipped to help our worship team members and others in the church. This journey of self-education has been both enlightening and humbling. I delved into books, attended webinars, and engaged with online communities dedicated to mental health awareness. I also reached out to professionals and experts in the field to gain valuable insights. This proactive approach has not only expanded my understanding of bipolar disorder but has also allowed me to provide more informed and empathetic support. It is a continuous process, and I'm committed to ensuring that our faith community is a place where everyone feels understood and cared for, regardless of the challenges they may face.

Participant 5 (Youth Leader - Interview) echoed this sentiment among youth leaders and said,

> Our youth leaders have a strong desire to learn. People want to understand bipolar disorder better so that people can be there for their peers. Education is a key step for us. This educational program recognized that knowledge is not just power but also compassion. It empowers us to provide the support, empathy, and guidance that our fellow youth members may need. The group embraced the idea that being well-informed about mental health, including conditions like bipolar disorder, is fundamental to creating a safe and nurturing environment within our church community. As youth leaders, we are committed to continually expanding our knowledge and sharing it with others to foster a more inclusive and supportive faith community.

Participant 7 (Worship Leader - Interview) outlined their commitment to education by sharing,

> As a worship leader, I felt a responsibility to educate myself about mental health, including bipolar disorder. It is part of our commitment to provide spiritual support to everyone in our church. This journey of self-education has been both enlightening and spiritually fulfilling. It is about aligning our faith with empathy and understanding, recognizing that mental health challenges affect members of our congregation as well. Through this educational program, I've gained valuable insights into bipolar disorder, its impact, and how we, as worship leaders, can be a source of comfort and solace. It is a testament to the evolving nature of our ministry, one that values both spiritual guidance and compassionate care for our church members.

In summary, Theme 1 intricately illustrates the participants' evolving awareness and understanding of bipolar disorder. While many initially grappled with limited knowledge, their resounding desire for education and awareness signified a collective effort to bridge the understanding gap and better serve their faith community.

Theme 2: Responses to Bipolar Disorder Situations

Within the overarching theme of "Responses to Bipolar Disorder Situations," participants' perspectives coalesce around two distinctive subthemes. These subthemes delve into the profound significance of compassion and empathy, as well as the recognition of the pivotal role played by professional help in responding to individuals affected by bipolar disorder.

Subtheme 2.1: Compassion and Empathy

Throughout the interviews and focus group discussions, it was evident that participants underscored the paramount importance of responding with compassion, empathy, and understanding when encountering individuals grappling with bipolar disorder. This subtheme illuminates their shared commitment to fostering a supportive environment within the faith community. Participant 2 (Youth Leader - Interview) articulated the essence of compassion by stating,

> Compassion means truly understanding the pain and struggles these individuals face. It is about walking alongside them, being there through the highs and lows, and letting them know they are not alone. It is a profound connection that transcends mere sympathy; it is a commitment to empathy and support. Through this educational program, I've come to appreciate that compassion is the cornerstone of effective leadership when dealing with individuals facing bipolar disorder. It is a reminder that as ministry leaders, our role extends beyond our titles, and we have the privilege of making a positive impact on the lives of those we serve.

Participant 6 (Counselor - Focus Group) emphasized the role of empathy by sharing,

> Empathy is about stepping into their shoes, seeing the world from their perspective. It is about validating their feelings and experiences, even if we do not fully understand them. It is a profound act of connecting on a human level, acknowledging the depth of their emotions, and offering a genuine response of care and support. Through this educational program, I've come to recognize that empathy is a bridge that allows us to connect with individuals facing bipolar disorder in a meaningful way. It is a reminder that as ministry leaders, our ability to empathize can create a safe and nurturing space where those in need can find solace and understanding.

Participant 8 (Counselor - Interview) encapsulated the collective sentiment by responding,

> In our ministry, compassion and empathy are at the core of our response. It is about creating a safe space where individuals with bipolar disorder feel valued and supported. We believe that every member of our faith community should find understanding and care, especially during their times of need. Through this educational program, we've reaffirmed our commitment to these principles and recognize that they are essential in providing the kind of spiritual and emotional support that individuals with bipolar disorder require. It is a testament to the values that guide our ministry, emphasizing the importance of inclusivity and compassion in all our interactions.

Subtheme 2.2: Seeking Professional Help

In this subtheme, participants unanimously recognized the significance of encouraging affected individuals to seek professional help when needed. They acknowledged that while compassion and empathy are pivotal, professional intervention is crucial for managing bipolar disorder effectively. Participant 3 (Worship Leader - Focus Group) underscored the importance of professional guidance and said,

> We can provide emotional support, but we also need to encourage them to seek professional help. It is about recognizing the boundaries of our role. Through this educational program, we've learned that while our ministry can offer understanding, comfort, and a sense of community, it is equally crucial to guide individuals toward the specialized care and expertise that professionals can provide. It is a delicate balance, one that acknowledges the limitations of our role as ministry leaders while also ensuring that those we serve receive the comprehensive help they need. This understanding underscores our commitment to the well-being of every member of our congregation.

Participant 4 (Counselor - Interview) elaborated on this perspective in their response where they said,

> As a counselor, I often emphasize the importance of professional therapy. It is an integral part of managing bipolar disorder, and we should actively guide them toward it. This educational program has reinforced my belief in the significance of specialized treatment and therapy for individuals dealing with bipolar disorder. It is about ensuring that they receive the best care available and equipping them with the tools to navigate their mental health journey effectively. As ministry leaders, we play a vital role in providing emotional support and facilitating access to these resources, fostering a holistic approach to care within our faith community.

Participant 7 (Worship Leader - Interview) echoed the consensus by answering,

> While we offer spiritual support, we also need to advocate for professional assistance when necessary. It is a holistic approach to their well-being. Through this educational program, I've come to appreciate the interconnectedness of spiritual and mental health. It is about recognizing that individuals with bipolar disorder may require a combination of support, including our spiritual guidance and the expertise of mental health professionals. As ministry leaders, we can bridge the gap between these realms, ensuring that those in need receive comprehensive care that addresses both their spiritual and mental well-being.

In summary, Theme 2 illuminate participants' collective commitment to responding to bipolar disorder situations with compassion, empathy, and an unwavering understanding. Simultaneously, they recognize the vital role of professional help, aligning their approach with a comprehensive and holistic framework for supporting individuals within the faith community.

Theme 3: Role of Ministry Leaders

Within the overarching theme of the "Role of Ministry Leaders," participants' perspectives converge on two distinctive subthemes. These subthemes delve into the pivotal roles played by ministry leaders in offering emotional support, guidance, and a safe space for individuals grappling with bipolar disorder, as well as the recognition of collaboration and communication as vital components of addressing this condition within the church setting.

Subtheme 3.1: Supportive Ministry Leaders

Throughout the interviews and focus group discussions, participants consistently underscored the central role of ministry leaders in providing vital emotional support, guidance, and a safe space for individuals contending with bipolar disorder. This subtheme accentuates the ministry leaders' commitment to nurturing a caring environment within the faith community. For instance, Participant 1 (Pastor - Interview) elucidated the significance of emotional support and said,

> As ministry leaders, our role goes beyond just preaching. It is about offering a shoulder to lean on, providing a listening ear, and being a source of comfort for those going through difficult times. This educational program has reinforced the idea that our ministry is not confined to the pulpit; it extends into the lives of our congregation members. We are called to be compassionate companions on their spiritual and emotional journeys, especially when they face challenges like bipolar disorder. It is a reminder that our actions and support can profoundly impact the lives of those we serve, creating a nurturing and caring faith community.

In addition, Participant 5 (Youth Leader - Interview) highlighted the role of guidance by sharing,

> We, as youth leaders, aim to guide our young members through life's challenges, including bipolar disorder. It is about providing direction and helping them navigate this journey. This educational program has emphasized our role as mentors and role models for the younger generation within our faith community. We recognize that adolescence and young adulthood can be particularly challenging, and being well-informed about mental health, including conditions like bipolar disorder, enables us to offer the guidance and support that our young members may need. It is a commitment to their growth and well-being, ensuring that they can rely on us as they navigate the complexities of life.

Moreover, Participant 8 (Counselor - Interview) encapsulated the shared perspective by sharing,

> Our ministry leaders are pillars of support. They create a space where individuals with bipolar disorder can openly express themselves, free from judgment. This educational program has reinforced the vital role that our ministry leaders play in fostering a welcoming and accepting environment within our faith community. It is about ensuring that every member, regardless of their mental health challenges, feels valued, heard, and supported. Our ministry leaders exemplify the qualities of compassion and inclusivity, demonstrating that the church is a place where individuals with bipolar disorder can find solace and understanding.

Subtheme 3.2: Collaboration and Communication

In this subtheme, participants collectively acknowledged the vital importance of collaboration among ministry leaders, pastoral staff, and professionals. They emphasized that effective communication and collaboration are essential components in addressing bipolar disorder within the church setting, ensuring a holistic approach to care. Participant 3 (Worship Leader - Focus Group) emphasized the value of collaboration and revealed,

> We realize that we can't do it alone. Collaborating with our pastoral staff and professionals in the mental health field strengthens our ability to support those with bipolar disorder. This educational program has emphasized the importance of teamwork and partnership within our faith community. We understand that addressing mental health

> challenges like bipolar disorder requires a multidisciplinary approach. By working hand in hand with our pastoral staff and mental health professionals, we can offer more comprehensive care and resources to those in need. It is a testament to our commitment to the well-being of our congregation members and the belief that we are stronger together.

Participant 4 (Counselor - Interview) elaborated on this perspective by stating,

> Collaboration ensures a seamless continuum of care. We communicate with pastoral staff and ministry leaders to provide a comprehensive support system. This educational program has reinforced the idea that effective communication and collaboration are at the heart of our approach to caring for individuals with bipolar disorder. By maintaining open lines of communication and working together cohesively, we can ensure that those in need have access to a holistic support network. It is a commitment to providing not just emotional and spiritual support but also a structured system that addresses their mental health needs. Collaboration is the cornerstone of our approach to care within our faith community.

Participant 6 (Counselor - Focus Group) echoed the consensus in their sentiments,

> In our ministry, we see collaboration as a force multiplier. It amplifies our impact and ensures that individuals with bipolar disorder receive the best care possible. This educational program has underscored the concept of synergy through collaboration. By pooling our resources, knowledge, and expertise, we can create a more significant and lasting impact on the lives of those we serve. It is about recognizing that together, we are stronger, and our collective efforts can provide individuals with bipolar disorder the comprehensive care and support they deserve. Collaboration is not just a strategy; it is a core principle that guides our ministry's approach to addressing mental health challenges within our faith community.

In summary, Theme 3 illuminates the integral roles played by ministry leaders in offering emotional support, guidance, and a safe space for individuals with bipolar disorder. Simultaneously, participants recognize that effective collaboration and communication among ministry leaders, pastoral staff, and professionals are crucial for addressing bipolar disorder within the church setting. This collective effort reflects a commitment to a holistic and comprehensive approach to care.

Theme 4: Barriers and Challenges

Within the overarching theme of "Barriers and Challenges," participants' perspectives converge on two distinctive subthemes. These subthemes shed light on the substantial obstacles

faced within the church community, including the persistence of stigma and a lack of awareness about bipolar disorder. Additionally, participants highlight the pressing need for specialized training and the availability of mental health resources to address these challenges effectively.

Subtheme 4.1: Stigma and Lack of Awareness

Throughout the interviews and focus group discussions, participants consistently identified stigma and a prevailing lack of awareness about bipolar disorder as significant barriers within the church community. This subtheme underscores the challenges posed by societal misconceptions and the need for transformative change in attitudes and understanding.

Participant 2 (Youth Leader - Focus Group) addressed the issue of stigma by saying,

> Stigma is a real problem. People often stereotype those with bipolar disorder, and this stigma can lead to exclusion and misunderstanding within our faith community. This educational program has shed light on the pervasive issue of stigma and its detrimental impact. It is about acknowledging that individuals with bipolar disorder, like anyone else, deserve to be treated with dignity and respect. As ministry leaders, we must actively work to challenge and dispel these stigmatizing beliefs within our faith community. It is a commitment to fostering a culture of acceptance and understanding, where everyone feels valued and supported, regardless of their mental health challenges.

Notably, Participant 6 (Counselor - Focus Group) emphasized the importance of awareness and added,

> Lack of awareness perpetuates the stigma. We need to educate our congregation about bipolar disorder to eliminate these harmful misconceptions. This educational program has emphasized the critical role of awareness and education in combating stigma. It is about recognizing that ignorance often fuels discrimination and misunderstanding. By proactively sharing information about bipolar disorder, its symptoms, and the challenges individuals face, we can dispel myths and promote empathy within our faith community. It is a commitment to shedding light on the reality of bipolar disorder, fostering a more informed and compassionate environment where stigma has no place.

In addition, Participant 7 (Worship Leader - Interview) highlighted the impact of stigma and shared,

> Stigma can prevent individuals from seeking help or reaching out for support. It is a significant barrier that we must confront. This educational program has highlighted the

> detrimental impact of stigma on individuals with bipolar disorder. Stigma can create a sense of shame and isolation, deterring people from seeking the assistance they need. As ministry leaders, we have a responsibility to address and break down these barriers. It is about creating an atmosphere of acceptance and understanding, where individuals with bipolar disorder feel comfortable seeking help and support without fear of judgment. Our commitment is to ensure that stigma does not stand in the way of anyone's well-being within our faith community.

Subtheme 4.2: Need for Training and Resources

In this subtheme, participants uniformly recognized the pressing need for specialized training and the availability of mental health resources within the church community. They emphasized that to address bipolar disorder effectively, ministry leaders must have the knowledge and tools required to provide informed support. For instance, Participant 3 (Worship Leader - Focus Group) stressed the importance of training and shared,

> Without proper training, we may inadvertently perpetuate misconceptions. Training equips us to respond effectively and with sensitivity. This educational program has underscored the significance of specialized training in addressing bipolar disorder within our faith community. It is about recognizing that without the right knowledge and skills, our well-intentioned efforts may inadvertently reinforce misunderstandings or stereotypes. Training ensures that we can provide informed and empathetic support to those in need. It is a commitment to continuous learning and growth as ministry leaders, with the aim of offering the best possible care and understanding to individuals with bipolar disorder.

Additionally, Participant 5 (Youth Leader - Interview) outlined the need for resources by stating,

> We need readily available resources within the church. This includes information, support networks, and access to mental health professionals who understand our faith context. This educational program has emphasized the importance of having a robust infrastructure of resources to address bipolar disorder effectively. It is about recognizing that individuals within our faith community should have easy access to information, guidance, and professionals who can provide care in a way that aligns with our faith values. Our commitment is to create an environment where seeking help for mental health concerns is met with understanding and accessibility, ensuring that no one faces these challenges alone.

Moreover, Participant 8 (Counselor - Interview) echoed the consensus and said,

> Training and resources go hand in hand. They empower us to break down barriers, dispel myths, and offer genuine support to those with bipolar disorder. This educational program has emphasized the symbiotic relationship between training and resources in

> addressing bipolar disorder. Training equips us with the knowledge and skills needed to provide informed support, while readily available resources ensure that individuals can access the help they require. It is a holistic approach to care, one that empowers us as ministry leaders to make a meaningful and lasting difference in the lives of those facing bipolar disorder. Our commitment is to ensure that both these elements are in place to create a supportive and compassionate faith community.

In summary, Theme 4 underscores the substantial barriers and challenges faced within the church community when addressing bipolar disorder. Participants collectively acknowledge the pervasive stigma and lack of awareness as formidable obstacles. Moreover, they emphasize the critical importance of specialized training and the availability of mental health resources as fundamental components in overcoming these challenges effectively. This recognition signifies a shared commitment to promoting a more informed and supportive faith community.

Theme 5: Available Resources and Support

Within the overarching theme of "Available Resources and Support," participants' perspectives coalesce around two distinctive subthemes. These subthemes illuminate the array of resources and support networks available within and outside the church community, offering vital assistance to individuals with bipolar disorder.

Subtheme 5.1: Church Resources

Throughout the interviews and focus group discussions, participants articulated the diverse resources the church community offers. These resources encompassed a spectrum of support, including counseling services, support groups, and access to mental health professionals, reflecting the church's commitment to providing comprehensive care. Participant 1 (Pastor - Interview) emphasized the role of church resources by stating,

> Our church offers counseling services tailored to mental health needs, including bipolar disorder. We believe in addressing both spiritual and emotional well-being. This educational program has highlighted the significance of providing comprehensive support to individuals within our faith community. We recognize that mental health challenges,

> including bipolar disorder, require a holistic approach to care. Our counseling services are a testament to our commitment to addressing the emotional and spiritual aspects of well-being. It is about creating a space where individuals can find guidance, understanding, and a sense of solace as they navigate their mental health journeys within our faith community.

In addition, Participant 4 (Counselor - Interview) highlighted the importance of support groups and revealed,

> Support groups within the church create a sense of belonging and understanding. They provide individuals with bipolar disorder a safe space to share their experiences. This educational program has reinforced the value of support groups as a crucial resource within our faith community. Support groups offer a unique opportunity for individuals facing bipolar disorder to connect with others who share similar challenges. It is about fostering a sense of camaraderie and empathy, where members can openly discuss their experiences and find solace in knowing they are not alone. Our commitment is to continue providing these supportive environments, where individuals can find comfort and understanding within our faith community.

Notably, Participant 7 (Worship Leader - Interview) underlined access to mental health professionals. They responded,

> Having mental health professionals within our church network is invaluable. It ensures that those in need can readily access specialized care. This educational program has emphasized the importance of bridging the gap between faith and mental health support. By having mental health professionals who understand our faith context, we offer individuals with bipolar disorder a safe and familiar space to seek help. It is about ensuring that our faith community is equipped to address mental health challenges comprehensively, combining our spiritual guidance with professional expertise. Our commitment is to continue fostering these partnerships, ensuring that everyone in need can access the care they deserve within our faith community.

Subtheme 5.2: External Resources

In this subtheme, participants offered recommendations for external resources, such as crisis hotlines and self-help materials. These external resources were seen as complementary tools to assist individuals affected by bipolar disorder, providing additional layers of support beyond the church community. Participant 3 (Worship Leader - Focus Group) highlighted the value of crisis hotlines by saying,

> Crisis hotlines can be a lifeline during difficult moments. They offer immediate support when individuals need it most, supplementing the resources within our church. This educational program has highlighted the vital role of crisis hotlines as an external resource. While our church provides valuable support, crisis hotlines offer an additional layer of assistance during urgent situations. They serve as a bridge to immediate help, ensuring that individuals facing bipolar disorder have access to timely support. Our commitment is to promote these external resources as a valuable complement to the care we provide within our faith community, emphasizing that help is always just a phone call away.

In addition, Participant 5 (Youth Leader - Interview) suggested the importance of self-help materials by outlining,

> Self-help materials can empower individuals to understand and manage their condition better. They can be a valuable resource for self-guided learning and growth. This educational program has emphasized the importance of equipping individuals with bipolar disorder with tools for self-empowerment. Self-help materials offer a way for them to gain insights, strategies, and coping mechanisms to navigate their journey. It is about providing individuals with the means to take an active role in their own well-being. Our commitment is to ensure that these self-help materials are readily available and accessible within our faith community, fostering a sense of agency and empowerment among those facing bipolar disorder.

Notably, Participant 8 (Counselor - Interview) echoed the consensus in their response,

> External resources serve as a safety net. They ensure that individuals with bipolar disorder have access to support around the clock, reinforcing the efforts of the church. This educational program has emphasized the complementary role of external resources in our overall support system. While our church provides assistance, external resources offer continuous support, even outside our regular hours of operation. They serve as a safety net, ensuring that help is available whenever it is needed. Our commitment is to promote these external resources as an integral part of our comprehensive care approach within our faith community, highlighting that individuals with bipolar disorder are never alone in their journey toward well-being.

In summary, Theme 5 illuminates the extensive resources and support networks available to individuals dealing with bipolar disorder. Participants collectively affirm the church's commitment to providing counseling services, support groups, and access to mental health professionals. Additionally, they underscore the value of external resources, such as crisis hotlines and self-help materials, as complementary tools to enhance the overall support system.

This multifaceted approach reflects a comprehensive commitment to the well-being of those within the faith community and beyond.

Theme 6: Leadership Steps for Knowledge and Awareness

Within the overarching theme of "Leadership Steps for Knowledge and Awareness," participants' perspectives coalesce around two distinctive subthemes. These subthemes illuminate the strategic actions and initiatives deemed vital by participants for enhancing knowledge and awareness of bipolar disorder within the church community.

Subtheme 6.1: Education and Awareness Campaigns

Throughout the interviews and focus group discussions, participants consistently underscored the paramount importance of educational initiatives and awareness campaigns within the church community. These initiatives were perceived as effective means of disseminating knowledge and dispelling myths surrounding bipolar disorder, thereby fostering understanding and empathy. Participant 1 (Pastor - Interview) highlighted,

> Education is a cornerstone of awareness. We must actively educate our congregation about bipolar disorder, using various platforms to reach different age groups. This educational program has reinforced the pivotal role of education in raising awareness within our faith community. It is about recognizing that knowledge is a powerful tool against stigma and misconceptions. By disseminating information about bipolar disorder through diverse channels and tailored to different age groups, we can ensure that our congregation is well-informed and empathetic. Our commitment is to continue these educational initiatives, fostering a culture of understanding and acceptance within our faith community.

In addition, Participant 4 (Counselor - Interview) explained the power of awareness campaigns and responded,

> Awareness campaigns create a buzz and draw attention. They can be a catalyst for open conversations and understanding within the church. This educational program has underscored the impact of awareness campaigns in sparking dialogue and fostering empathy. These campaigns serve as a means to engage our faith community actively. They encourage conversations, questions, and a deeper understanding of bipolar disorder.

> Our commitment is to continue these awareness campaigns, using them as a vehicle to promote a culture of compassion, inclusivity, and open dialogue within our church.

Agreeably, Participant 6 (Counselor - Focus Group) emphasized the need for ongoing education and said,

> Education and awareness should be continuous efforts. We need to keep the conversation alive and evolving within our faith community. This educational program has emphasized the importance of sustainability in our educational and awareness initiatives. It is about recognizing that maintaining a culture of understanding and empathy requires ongoing engagement. We must ensure that the conversation about bipolar disorder remains dynamic and adaptable to changing needs. Our commitment is to foster an environment where education and awareness are not static but evolve with our faith community's growth and development.

Subtheme 6.2: Creating a Supportive Culture

Participants articulated the significance of fostering a culture of empathy, inclusivity, and open dialogue within the church community. They recognized that creating such a culture was essential for gaining knowledge and awareness of bipolar disorder and ensuring that individuals affected by the condition felt valued and supported. Participant 2 (Youth Leader - Focus Group) stressed the role of empathy and shared,

> Empathy is the cornerstone of our culture. It is about walking in each other's shoes and creating an environment where everyone feels heard and understood. This educational program has reaffirmed the centrality of empathy in our faith community. It is about recognizing that empathy is not just a value but a way of life. It is the foundation of our interactions, where we strive to understand each other's perspectives and emotions. Our commitment is to continue nurturing this culture of empathy, ensuring that every member of our faith community feels valued and supported, regardless of their circumstances or challenges.

Participant 5 (Youth Leader - Interview) posited the importance of inclusivity by revealing,

> Inclusivity means that everyone has a place at the table, regardless of their struggles. It is about embracing diversity and standing together. This educational program has reinforced the importance of inclusivity as a fundamental principle in our faith community. It is about acknowledging that inclusivity is not just a goal but a commitment to valuing every individual's unique journey. We stand united in our support, ensuring that no one is left behind due to their challenges or differences. Our commitment is to continue championing inclusivity, creating a space where everyone feels welcomed and accepted within our faith community.

Additionally, Participant 8 (Counselor - Interview) underlined open dialogue and stressed,

> Open dialogue is essential. It encourages individuals to share their experiences, ask questions, and seek support without fear of judgment. This educational program has highlighted the pivotal role of open dialogue in our faith community. It is about fostering an atmosphere where communication is free and transparent, enabling individuals to express themselves authentically. Our commitment is to continue promoting open dialogue, ensuring that conversations about bipolar disorder and mental health are met with understanding, compassion, and a willingness to support one another within our faith community.

In summary, Theme 6 elucidates the strategic leadership steps identified by participants for enhancing knowledge and awareness of bipolar disorder within the church community. They collectively affirm the pivotal roles of education and awareness campaigns in disseminating knowledge. Simultaneously, they underscore the importance of fostering a supportive culture characterized by empathy, inclusivity, and open dialogue. These actions reflect a dedicated commitment to promoting knowledge, awareness, and a compassionate faith community.

Conclusion

The findings of this comprehensive mixed-methods study are presented, focusing on enhancing understanding and awareness of bipolar disorder among ministry leaders serving adolescents and young adults within a church community. The study integrated both quantitative and qualitative data analyses to investigate the impact of an eight-week educational program.

The quantitative findings from the paired samples t-test analysis of the pretest and posttest survey questions indicated statistically significant differences in participants' responses following the completion of the educational program. Across all eight questions, participants significantly improved their knowledge and comprehension of bipolar disorder, church-related stigmas, symptoms, and coping strategies. These findings support the study's hypothesis that the educational program would enhance the participants' grasp of ministry leadership guidance in addressing bipolar disorder within the church setting.

Complementing the quantitative data, the qualitative analysis uncovered six overarching themes, each with corresponding subthemes. These themes provided a deeper understanding of the experiences and perspectives of ministry leaders in the context of bipolar disorder. The first theme, "Understanding and Awareness of Bipolar Disorder," revealed that participants initially had limited knowledge and understanding of bipolar disorder but expressed a strong desire to learn more about it. This theme highlighted the importance of education and awareness.

The second theme, "Responses to Bipolar Disorder Situations," emphasized the significance of responding with compassion, empathy, and understanding when interacting with individuals affected by bipolar disorder. Encouraging affected individuals to seek professional help was also recognized as essential. The third theme, "Role of Ministry Leaders," shed light on the multifaceted role of ministry leaders in providing emotional support, guidance, and safe spaces for individuals with bipolar disorder. Collaboration among ministry leaders, pastoral staff, and professionals was seen as vital in addressing bipolar disorder within the church setting.

The fourth theme, "Barriers and Challenges," identified stigma and a lack of awareness as significant barriers within the church community. Participants also acknowledged the need for specialized training and readily available mental health resources within the church to address bipolar disorder effectively. The fifth theme, "Available Resources and Support," described the church's offerings, including counseling services, support groups, access to mental health professionals, and recommended external resources to assist affected individuals.

The sixth theme, "Leadership Steps for Knowledge and Awareness," emphasized the importance of educational initiatives and awareness campaigns within the church community. It also highlighted the need to foster a culture of empathy, inclusivity, and open dialogue to enhance knowledge and awareness. In summary, the findings from this study suggest that an

eight-week educational program can significantly enhance the knowledge and awareness of ministry leaders, equipping them with the skills and understanding needed to support adolescents and young adults with bipolar disorder. The qualitative data provided deeper insights into ministry leaders' nuanced experiences and perspectives in this context, complementing the quantitative results. These findings hold important implications for developing more inclusive and supportive church communities that address the needs of individuals with bipolar disorder and other mental health challenges.

CHAPTER 5: CONCLUSION

Introduction

Throughout this study, the researcher has explored the complex dynamics surrounding this issue, investigated the impact of an eight-week educational program for ministry leaders (see Appendix J) for the PowerPoint presentations, and delved into the experiences and perspectives of those on the frontlines of ministry. Each week of the program was structured around a PowerPoint presentation that covered various aspects of bipolar disorder, including understanding the disorder, recognizing symptoms, addressing church stigmas, understanding different types of bipolar disorders, identifying biblical perspectives on special needs, exploring examples of sensory overload, understanding leadership alert measures, and increasing awareness of self-aid coping care skills. In addition to the PowerPoint presentations, the program incorporated various educational activities to reinforce the learning objectives. These activities included individual interviews and focus groups, which provided participants with opportunities to share their experiences, ask questions, and engage in discussions about the topics covered in the program. The concluding chapter revisits this research's significance, aims, and hypothesis and provides a thorough overview of the key components that encapsulate the journey.

The significance of this research lies in its commitment to bridging the gap between mental health and faith communities, recognizing that individuals with bipolar disorder often encounter stigma, misunderstanding, and a lack of support within religious contexts. By addressing this gap, this paper endeavors to create a more inclusive and compassionate

environment within the church, one that fosters understanding and provides a platform for those affected by bipolar disorder to thrive.

This research assessed the impact of an eight-week educational program on ministry leaders' knowledge, attitudes, and readiness to support adolescents and young adults with bipolar disorder. In doing so, the researcher sought to test the hypothesis that this program would enhance ministry leaders' comprehension and capabilities in addressing the challenges posed by bipolar disorder within the church.

This chapter will comprehensively summarize the key findings of the research, encompassing both quantitative and qualitative data. The researcher will then delve into the implications of these findings, shedding light on the potential transformative effects of educational programs for ministry leaders and the broader church community. Moreover, this chapter explores the practical applications of this research, outlining strategies for implementing educational initiatives and support systems within faith communities.

While the research findings hold significant promise, it is essential to acknowledge the limitations and constraints encountered during the research process. These limitations offer valuable insights into the complexities of addressing mental health within a religious context, and they underscore the need for further exploration in this vital field.

Finally, this chapter concludes this study with recommendations for future research endeavors, providing a roadmap for continued progress in the intersection of mental health and faith communities. The researcher hopes this work becomes a catalyst for broader conversations, informed actions, and lasting positive change in how individuals with bipolar disorder are supported and embraced within the church and, by extension, within society.

Summary of the Key Findings

The key findings of this research encompass a rich tapestry of insights gleaned from both quantitative and qualitative data. These findings shed light on the understanding, attitudes, and responses of ministry leaders within the Love Faith Church (LFC) when it comes to supporting adolescents and young adults with bipolar disorder. The study employed an eight-week educational program to assess the impact on ministry leaders, and the results offer valuable implications for addressing mental health within faith communities.

Understanding and Awareness of Bipolar Disorder

One of the prominent findings of this research is that before the educational program, many ministry leaders had limited knowledge and understanding of bipolar disorder. They acknowledged that this mental health condition was a mysterious and unfamiliar concept to them. However, there was a strong desire among these leaders to learn more about bipolar disorder, its symptoms, and its impact on young individuals. This newfound knowledge was perceived as a fundamental step in providing effective support within the church community.

Responses to Bipolar Disorder Situations

Ministry leaders highlighted the significance of responding with compassion, empathy, and understanding when encountering individuals with bipolar disorder. Compassion was viewed as a means of genuinely understanding the struggles faced by those with the condition, while empathy was seen as the ability to step into their shoes and validate their experiences. Encouraging affected individuals to seek professional help when needed was another key response emphasized by ministry leaders. This dual approach of compassion and professional support formed the cornerstone of their response strategies.

Role of Ministry Leaders

The role of ministry leaders in providing emotional support, guidance, and a safe space for individuals with bipolar disorder was emphasized as crucial. These leaders recognized the importance of fostering a supportive culture where affected individuals felt valued and understood. Collaboration among ministry leaders, pastoral staff, and professionals in the mental health field was seen as vital in addressing bipolar disorder within the church setting. This collaborative approach ensured a comprehensive and holistic support system.

Barriers and Challenges

Stigma and a lack of awareness about bipolar disorder were identified as significant barriers within the church community. These barriers perpetuated misconceptions and hindered individuals from seeking help or support. Participants recognized the need for specialized training and readily available mental health resources within the church to address bipolar disorder effectively. These findings underscored the importance of addressing stigma and investing in education and resources.

Available Resources and Support

Within the Love Faith Church, participants described a range of resources available to individuals with bipolar disorder. These included counseling services, support groups, and access to mental health professionals. Recommendations for external resources, such as crisis hotlines and self-help materials, were also mentioned to supplement the church's offerings. The availability of both church-based and external resources was perceived as vital in providing comprehensive support.

Leadership Steps for Knowledge and Awareness

Education and awareness campaigns were highlighted as key steps in gaining knowledge and awareness within the church community. Participants emphasized the importance of continuous efforts to educate the congregation about bipolar disorder, using various platforms to reach different age groups. Additionally, fostering a culture of empathy, inclusivity, and open dialogue was essential in building knowledge and awareness.

In summary, the key findings of this research reveal the transformative potential of education and awareness initiatives within faith communities. Ministry leaders' understanding and attitudes toward bipolar disorder improved significantly after the educational program, emphasizing the importance of targeted training. The findings underscore the pivotal role of compassion, empathy, and collaboration in providing effective support, as well as the necessity of addressing stigma and promoting inclusivity. The availability of resources, both within the church and externally, enhances the support system for individuals with bipolar disorder. Lastly, the research findings advocate for ongoing efforts in education, awareness, and cultivating a supportive culture within faith communities.

Research Implications

The findings of this study carry several significant implications across various domains, including academia, mental health advocacy, religious organizations, and the broader community. These implications highlight the potential for positive change and improvement in supporting adolescents and young adults with bipolar disorder.

Academic Implications

Enhancing Mental Health Education

This research underscores the importance of enhancing mental health education within religious and academic institutions. Academic institutions can take cues from this study to develop and implement courses, workshops, and training programs that equip future ministry leaders, counselors, and religious professionals with the knowledge and skills to support individuals with bipolar disorder.[1] By incorporating mental health awareness into the curriculum, academic institutions can contribute to the development of compassionate and informed leaders.

Interdisciplinary Collaboration

The study's emphasis on collaboration between ministry leaders and mental health professionals suggests the value of interdisciplinary cooperation. Academic institutions can encourage collaboration between theology, psychology, and social work departments to bridge the gap between faith-based support and evidence-based mental health care.[2] Research centers and academic conferences can also provide platforms for scholars from various disciplines to share knowledge and insights.

Research in Faith and Mental Health

This study contributes to the growing body of research at the intersection of faith and mental health. It highlights the need for more research examining the roles of religious leaders and faith communities in supporting individuals with bipolar disorder and other mental health

[1] Eva Ouwehand et al., "Revelation, Delusion or Disillusion: Subjective Interpretation of Religious and Spiritual Experiences in Bipolar Disorder," *Mental Health, Religion & Culture* 17, no. 6 (2014): 615–28, doi:10.1080/13674676.2013.874410.

[2] "Mental Health Professionals and Interdisciplinary Collaboration," *Resolving Family Conflicts*, 2017, 489–506, doi:10.4324/9781315244365–22.

conditions. Academic institutions can encourage research initiatives that explore the effectiveness of educational programs and interventions in faith-based settings[3].

Mental Health Advocacy Implications

Reducing Stigma

The findings emphasize the detrimental effects of stigma on individuals with bipolar disorder. Mental health advocacy organizations can collaborate with religious institutions to develop stigma-reduction campaigns tailored to faith communities.[4] These campaigns can raise awareness, challenge misconceptions, and promote empathy and understanding.

Mental health advocacy groups can advocate for the inclusion of mental health training in the curriculum of religious institutions and seminaries.[5] They can also provide resources and guidelines for developing and implementing educational programs like the one examined in this study.

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[3] Stephen Handsley, "Faith, Mental Health and Deviance: Possession or Illness?" *Religion, Faith and Crime*, 2016, 89–111, doi:10.1057/978–1–137–45620–5_5.

[4] "Supplemental Material for Stigma Toward Mental Illness and Substance Use Disorders in Faith Communities: The Roles of Familiarity and Causal Attributions," *Stigma and Health*, 2022, doi:10.1037/sah0000373.supp.

[5] Bibhav Acharya et al., "Developing a Global Mental Health Training Curriculum," *Global Mental Health Training and Practice*, 2023, 81–95, doi:10.4324/9781315160597–7.

Religious Organizations' Implications

Creating Supportive Environments

Religious organizations can implement the insights from this research to create supportive environments for individuals with bipolar disorder. This includes fostering cultures of empathy, compassion, and inclusivity within congregations and religious leadership.[6]

Developing Resources

Building on the availability of resources, religious organizations can actively collaborate with mental health professionals to develop comprehensive support systems. This may involve establishing counseling services, support groups, and partnerships with external mental health organizations.[7]

Community Implications

Raising Community Awareness

The study highlights the significance of community-wide awareness and education about bipolar disorder. Local community organizations, schools, and religious institutions can work together to organize awareness campaigns, workshops, and seminars that promote mental health literacy and reduce stigma.[8]

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[6] Eva Ouwehand et al., "Revelation, Delusion or Disillusion: Subjective Interpretation of Religious and Spiritual Experiences in Bipolar Disorder," *Mental Health, Religion & Culture* 17, no. 6 (2014): 615–28, doi:10.1080/13674676.2013.874410.

[7] Stephen Handsley, "Faith, Mental Health and Deviance: Possession or Illness?" *Religion, Faith and Crime*, 2016, 89–111, doi:10.1057/978–1–137–45620–5_5.

[8] Tatiana Torti Giampaolo Perna and Alessandra Alciati, "Effects of Public Awareness and Stigmatization on Accurate and Timely Diagnosis of Bipolar Disorder," *The Bipolar Book*, 2015, 73–78, doi:10.1093/med/9780199300532.003.0006.

Providing Access to Resources

Communities can advocate for the availability of mental health resources, such as crisis hotlines and self-help materials, to ensure that individuals with bipolar disorder have access to support beyond the confines of religious organizations.[9] In conclusion, the research implications of this study extend to academia, mental health advocacy, religious organizations, and the wider community. These implications emphasize the importance of education, collaboration, and resource development in supporting individuals with bipolar disorder within faith-based settings and beyond.

Research Applications

The findings of this research offer valuable insights that can be applied in various practical contexts, including religious institutions, mental health services, and educational settings. These applications are essential for improving the support and well-being of adolescents and young adults with bipolar disorder.

Faith-Based Organizations

Educational Programs

The most immediate application is within religious organizations themselves. They can utilize the Ministry Leaders' Educational Plan developed in this study to educate their ministry leaders about bipolar disorder and related mental health issues. By implementing similar educational programs, faith-based institutions can enhance the capacity of their leaders to provide effective support[10]. One of the most critical applications of this study's findings is the

[9] Perna and Alciati, "Effects of Public Awareness.

[10] Ibid.

development and implementation of educational programs within religious organizations. The Ministry Leaders' Educational Plan, formulated through this study, represents a vital tool in enhancing the awareness and understanding of bipolar disorder and related mental health issues among faith-based leaders.

Immediate Application within Religious Organizations

Religious institutions play a significant role in the lives of their congregants, providing spiritual guidance, emotional support, and a sense of community. However, the lack of awareness and understanding of mental health issues, such as bipolar disorder, within these organizations can create barriers to providing effective support.[11] This is where the immediate application of the Ministry Leaders' Educational Plan becomes paramount.

Utilizing the Ministry Leaders' Educational Plan

The Ministry Leaders' Educational Plan serves as a structured curriculum that equips ministry leaders with the knowledge, tools, and resources needed to comprehend and address bipolar disorder within their congregations. This plan is specifically designed to bridge the gap between faith and mental health by providing comprehensive training that addresses both the spiritual and mental well-being of individuals.

Enhancing Capacity for Support

By implementing the Ministry Leaders' Educational Plan or similar educational programs, faith-based institutions can significantly enhance the capacity of their leaders to

[11] Brisa S. Fernandes, "The Treatment of Bipolar Disorder in the Era of Precision Psychiatry: Challenges and Opportunities," *Neurobiology of Bipolar Disorder*, 2021, 405–15, doi:10.1016/b978–0–12–819182–8.00038–7.

provide effective support.[12] Education empowers ministry leaders to gain a deeper understanding of bipolar disorder, including its symptoms, challenges, and treatment options. This knowledge allows them to recognize the signs and symptoms more readily, reducing the risk of misinterpretation or stigmatization.

The educational programs can address the stigmas and misconceptions surrounding mental health issues. Leaders can learn to promote an environment of empathy and acceptance, reducing the stigma attached to bipolar disorder within their communities. In addition, education equips leaders with the communication skills necessary to engage in open and empathetic conversations with individuals affected by bipolar disorder. This can lead to improved pastoral care and support. Furthermore, leaders can learn when and how to refer individuals to professional mental health services.[13] This collaboration between faith-based organizations and mental health professionals ensures that individuals receive holistic care. Moreover, educational programs emphasize the importance of creating supportive environments within religious settings. Leaders can actively work towards fostering a culture of inclusion and understanding.

Long-Term Impact

The long-term impact of such educational programs is profound. As ministry leaders become better equipped to address mental health issues, including bipolar disorder, they can create an environment where individuals feel safe, supported, and valued. This not only improves the well-being of those living with bipolar disorder but also strengthens the overall sense of community and inclusivity within the religious organization.

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[12] Patricia Barkway, "Creating Supportive Environments for Mental Health Promotion in the Workplace," *Contemporary Nurse* 21, no. 1 (2006): 131–41, doi:10.5172/conu.2006.21.1.131.

[13] "Mental Health Professionals and Interdisciplinary Collaboration," *Resolving Family Conflicts*, 2017, 489–506, doi:10.4324/9781315244365–22.

Faith-based organizations can work on fostering environments that are inclusive and welcoming for individuals with bipolar disorder. This can involve regular awareness campaigns, workshops, and support groups within congregations. Supportive environments within faith-based organizations represent a transformative approach to addressing the needs of individuals with bipolar disorder.[14] These environments go beyond merely acknowledging the existence of mental health conditions; they actively promote inclusivity, understanding, and compassion within the faith community.

Awareness Campaigns and Workshops

Faith-based organizations can take proactive steps by initiating regular awareness campaigns and workshops. These initiatives can serve multiple purposes. Firstly, they educate congregants about bipolar disorder, dispelling myths and stereotypes.[15] Secondly, they foster empathy by encouraging individuals to step into the shoes of those living with bipolar disorder, promoting a deeper understanding of their struggles. Awareness campaigns and workshops provide a platform for open discussions and the sharing of personal experiences, reducing the stigma surrounding mental health conditions.

Support Groups

Establishing support groups within congregations is another crucial component of creating supportive environments. These groups provide a safe and confidential space for individuals with bipolar disorder to share their journeys, seek advice, and receive emotional

[14] Brisa S. Fernandes, "The Treatment of Bipolar Disorder in the Era of Precision Psychiatry: Challenges and Opportunities," *Neurobiology of Bipolar Disorder*, 2021, 405–15, doi:10.1016/b978–0–12–819182–8.00038–7.

[15] Perna, "Effects of Public Awareness."

support.[16] They also serve as a means for congregants to actively engage in the well-being of their fellow members. By participating in support groups, individuals can learn about the challenges faced by those with bipolar disorder and discover ways to offer assistance, both within and outside the faith community.

Long-Term Impact

The long-term impact of fostering supportive environments is profound. It not only improves the quality of life for individuals with bipolar disorder but also strengthens the fabric of the faith community itself. Congregations that actively work towards creating such environments become beacons of empathy, understanding, and inclusion. This paradigm shift in faith-based organizations contributes to breaking down societal stigmas associated with mental health conditions and paves the way for a more compassionate and supportive society.

Faith-based organizations can establish partnerships with mental health professionals, ensuring that individuals with bipolar disorder have access to both spiritual and clinical support when needed. Collaboration between faith-based organizations and mental health professionals represents a pivotal step in providing comprehensive care for individuals with bipolar disorder. By forging partnerships with mental health experts, faith communities can offer a holistic support system that addresses both the spiritual and clinical aspects of mental health.

Integrated Care

Faith-based organizations can work towards establishing integrated care models that seamlessly blend spiritual and clinical support. This approach ensures that individuals with

[16] Polina Eidelman et al., "Social Support and Social Strain in Inter-Episode Bipolar Disorder," *Bipolar Disorders* 14, no. 6 (2012): 628–40, doi:10.1111/j.1399–5618.2012.01049.x.

bipolar disorder have access to a range of services, from pastoral counseling to professional therapy.[17] The synergy between these two realms of care recognizes the complexity of mental health and acknowledges that individuals may require different forms of support at various stages of their journey.

Breaking Down Barriers

Collaboration with mental health professionals also helps break down barriers that individuals with bipolar disorder may encounter when seeking treatment.[18] By offering a bridge to clinical resources, faith communities reduce the stigma associated with professional mental health care. This collaborative effort normalizes the idea that seeking help from mental health professionals is a natural and encouraged step in managing bipolar disorder.

Community Impact

Beyond its direct benefits to individuals with bipolar disorder, collaboration with mental health professionals has a positive ripple effect on the entire faith community. It fosters a culture of empathy and understanding, where mental health is destigmatized, and congregants are encouraged to support one another in times of need.[19] Additionally, such partnerships strengthen the credibility of faith-based organizations as advocates for mental health awareness and inclusivity.

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[17] Christopher Schneck, "Treating Depression and Bipolar Disorder in Integrated Care Settings," *Oxford Medicine Online*, 2017, doi:10.1093/med/9780190276201.003.0012.

[18] Brisa S. Fernandes, "The Treatment of Bipolar Disorder in the Era of Precision Psychiatry: Challenges and Opportunities," *Neurobiology of Bipolar Disorder*, 2021, 405–15, doi:10.1016/b978–0–12–819182–8.00038–7.

[19] Polina Eidelman et al., "Social Support and Social Strain in Inter-Episode Bipolar Disorder," *Bipolar Disorders* 14, no. 6 (2012): 628–40, doi:10.1111/j.1399–5618.2012.01049.x.

A Holistic Approach

This holistic approach to care represents a powerful testament to the commitment of faith-based organizations to the well-being of their members. By combining spiritual and clinical resources, they ensure that individuals with bipolar disorder receive the comprehensive support they need, ultimately contributing to their overall health and resilience.

Mental Health Services

Interdisciplinary Collaboration

Mental health service providers can collaborate more closely with faith-based organizations to offer holistic care. By integrating spiritual support with clinical services, individuals with bipolar disorder can receive comprehensive care that addresses mental, emotional, and spiritual needs. Interdisciplinary collaboration presents a promising avenue for enhancing the care provided to individuals with bipolar disorder.[20] Mental health service providers can work closely with faith-based organizations to create a unified approach that encompasses both spiritual and clinical support. This collaborative effort seeks to address the complex needs of individuals with bipolar disorder comprehensively.

Comprehensive Care

The fusion of spiritual and clinical services ensures that individuals with bipolar disorder receive holistic care that considers their mental, emotional, and spiritual well-being.[21] This

[20] "Mental Health Professionals and Interdisciplinary Collaboration," *Resolving Family Conflicts*, 2017, 489–506, doi:10.4324/9781315244365–22.

[21] Christopher Schneck, "Treating Depression and Bipolar Disorder in Integrated Care Settings," *Oxford Medicine Online*, 2017, doi:10.1093/med/9780190276201.003.0012.

integrated approach acknowledges that a person's mental health is intricately linked to their spiritual journey and that both aspects are vital in achieving overall wellness.

Reducing Stigma

Interdisciplinary collaboration also plays a crucial role in reducing the stigma associated with seeking mental health support. By offering spiritual leaders and mental health professionals as partners in care, individuals may be more inclined to reach out for help. This approach normalizes the idea that mental health challenges are a part of the human experience and can be effectively managed with a multifaceted support system.

Enhanced Well-Being

Collaborative efforts between mental health providers and faith-based organizations have the potential to enhance the well-being of individuals with bipolar disorder significantly. They gain access to a wider range of resources, support networks, and coping strategies, ultimately empowering them to better manage their condition and lead fulfilling lives.

Community Resilience

Beyond individual benefits, interdisciplinary collaboration strengthens the resilience of faith communities. It promotes inclusivity, open dialogue about mental health, and a culture of support and empathy. This not only benefits those directly impacted by bipolar disorder but also contributes to a healthier and more compassionate communities.

Training for Religious Leaders

Mental health services can offer training programs for religious leaders and ministry teams, helping them develop a deeper understanding of mental health conditions like bipolar

disorder and enhancing their supportive capabilities. Mental health services have a unique opportunity to empower religious leaders and ministry teams through targeted training programs. These initiatives are designed to equip them with a more profound understanding of mental health conditions, including bipolar disorder, and enhance their capacity to provide effective support within their faith communities.

Knowledge Expansion

Training programs offer religious leaders and ministry teams the chance to expand their knowledge about bipolar disorder and related mental health conditions. This education includes an exploration of the disorder's symptoms, treatment options, and the challenges individuals face.[22] Armed with this knowledge, spiritual guides can approach mental health issues with greater sensitivity and understanding.

Reducing Stigma

One of the significant implications of training is the reduction of stigma within faith communities. By promoting accurate information and dispelling myths surrounding bipolar disorder, religious leaders can foster environments where individuals can openly discuss their mental health concerns.[23] This contributes to breaking down barriers to seeking help and promotes a culture of acceptance and empathy.

[22] Bibhav Acharya et al., "Developing a Global Mental Health Training Curriculum," *Global Mental Health Training and Practice*, 2023, 81–95, doi:10.4324/9781315160597–7.

[23] Perna, "Effects of Public Awareness."

Enhanced Support

Training not only increases awareness but also enhances the supportive capabilities of religious leaders and ministry teams. They learn effective strategies for offering emotional and spiritual guidance to individuals with bipolar disorder.[24] This includes knowing when to refer someone to professional mental health services and how to create a supportive and inclusive environment within their congregations.

A Unified Approach

Collaboration between mental health services and faith-based organizations in providing training programs creates a unified approach to mental health support. It bridges the gap between the spiritual and clinical aspects of well-being, ensuring that individuals with bipolar disorder receive comprehensive care that addresses both their emotional and spiritual needs.

A Path to Healing

Training for religious leaders is a crucial step towards promoting healing and well-being among individuals with bipolar disorder. It recognizes the influential role that spiritual guides play in the lives of their congregants and empowers them to contribute positively to the mental heEducational Institutions

Curriculum Enhancement

Educational institutions have a pivotal role to play in advancing mental health awareness and advocacy within religious and community settings. By reviewing and enhancing their

[24] Eidelman et al., “Social Support and Social Strain.”

curricula to include mental health education, these institutions can equip future leaders, including ministry leaders, counselors, and educators, to be well-informed advocates for mental health.

Comprehensive Education

Incorporating mental health education into academic curricula provides students with comprehensive knowledge about mental health conditions. This includes bipolar disorder. Leveraging a holistic approach ensures that future leaders are equipped with theoretical understanding, practical skills, and empathy to address mental health challenges effectively.

Reducing Stigma

Educational institutions have the power to reduce stigma. One key means is promoting open conversations about mental health. By addressing stereotypes, misconceptions, and biases surrounding bipolar disorder, students can develop a more compassionate and non-judgmental approach when working with individuals facing mental health issues.

Building a Supportive Network

Enhanced curricula foster the development of a supportive network of future leaders who are passionate about mental health advocacy. Students studying various disciplines, from ministry to counseling, can collaborate and share insights. Creating a multidisciplinary approach to addressing mental health within religious and community settings is a powerful step.

Leadership Development

Educational institutions play a crucial role in nurturing leadership qualities among their students. With a focus on mental health education, these institutions prepare future leaders to

take proactive steps. Then they can better advocate for the mental well-being of their congregations and communities.

A Holistic Approach

By including mental health education in their curricula, educational institutions underscore the importance of holistic well-being. They emphasize that mental health is integral to a person's overall health. Challenging students to adopt a more comprehensive perspective in their future roles as ministry leaders, counselors, and educators is necessary.

Advancing Advocacy

Ultimately, curriculum enhancement paves the way for the emergence of informed advocates committed to advancing mental health awareness within religious and community settings. These advocates are instrumental in promoting positive change and reducing stigma. These people help ensure that individuals with bipolar disorder receive the support and understanding they deserve.

Research Initiatives

Academic institutions have a significant role to play in advancing knowledge and understanding at the intersection of faith and mental health. These institutions can contribute to the academic literature and provide evidence-based insights for enhancing mental health within religious contexts. This can happen by initiating research projects focusing on this critical area.

Efficacy of Educational Programs

One crucial area of research could center on evaluating the efficacy of educational programs, such as the Ministry Leaders' Educational Plan developed in this study. Academic

researchers can design rigorous studies to assess the impact of such programs on the knowledge, attitudes, and practices of ministry leaders and congregations. By employing both quantitative and qualitative research methods, these studies can provide a nuanced understanding of how faith-based educational interventions influence mental health awareness and support.

Exploring Unique Approaches

Research initiatives can delve into the exploration of unique approaches and best practices in promoting mental health within religious communities. These projects can investigate the role of faith leaders, the effectiveness of support groups, the impact of awareness campaigns, and the experiences of individuals with bipolar disorder within faith-based environments. By shedding light on these aspects, academic research can guide the development of tailored interventions and resources.

Longitudinal Studies

Academic institutions can engage in longitudinal research to track the long-term outcomes of mental health initiatives within faith communities. This approach allows researchers to assess the sustainability of awareness efforts, the evolution of attitudes and practices, and the enduring impact on individuals with bipolar disorder. Longitudinal studies provide valuable insights into the trajectory of mental health support within faith-based settings.

Interdisciplinary Collaboration

Research projects can advance interdisciplinary collaboration between mental health experts, theologians, sociologists, and other fields. By bringing together diverse perspectives, academic institutions can foster a holistic understanding of faith and mental health. This

collaboration can lead to innovative research methodologies and comprehensive findings that address the complex interplay between faith, mental health, and community support.

Contributions to the Academic Literature

Ultimately, research initiatives initiated by academic institutions can contribute significantly to the academic literature on faith and mental health. They can offer empirical evidence, theoretical frameworks, and practical insights that enrich the discourse surrounding this critical intersection. These contributions advance knowledge within the academic community and inform policymakers, faith leaders, and mental health practitioners striving to create supportive environments for individuals with bipolar disorder and related mental health conditions.

Community and General Public

Promotion of Mental Health Literacy

The research findings underscore the importance of promoting mental health literacy within communities. This imperative extends to various stakeholders, including local community organizations, schools, and individuals. By proactively raising awareness and combat the stigma associated with bipolar disorder and mental health in general, communities can foster an environment of empathy, understanding, and support.

Community Organizations as Advocates

Local community organizations play a pivotal role in advocating for mental health literacy. They can initiate awareness campaigns, workshops, and support groups tailored to the specific needs of their communities. These initiatives can serve as platforms for individuals to learn about bipolar disorder, share their experiences, and find solace in a supportive network.

Additionally, community organizations can collaborate with mental health professionals to ensure access to resources and guidance.

Educational Institutions as Catalysts

Schools are essential hubs for fostering mental health literacy among young generations. Educational institutions can incorporate mental health education into their curricula, equipping students with knowledge about conditions like bipolar disorder and strategies for emotional well-being. Additionally, schools can organize awareness events, inviting mental health experts and individuals with lived experiences to share their insights and perspectives. By nurturing mental health literacy early on, schools contribute to building a more compassionate and informed society.

Individual Commitment to Learning

Individuals within communities also have a crucial role to play in promoting mental health literacy. Everyone can take the initiative to educate themselves about bipolar disorder and related mental health issues. This commitment to learning can occur through reading reliable sources, attending workshops, or engaging in open conversations with peers and family members. By becoming informed advocates, individuals can challenge stereotypes, offer support, and contribute to the broader mission of reducing stigma.

Destigmatizing Conversations

Open and destigmatizing conversations about mental health are key to fostering mental health literacy. Communities can create safe spaces for dialogue where individuals feel comfortable discussing their struggles and seeking help. By encouraging candid conversations, communities can break down the barriers of silence and isolation often experienced by those

with bipolar disorder. These conversations help normalize the topic of mental health, making it a part of everyday discourse.

Cultivating Compassion and Empathy

A culture of compassion and empathy is foundational to promoting mental health literacy. Communities can actively work on nurturing these values, encouraging individuals to understand and support one another. By cultivating empathy, communities create an atmosphere where individuals with bipolar disorder are embraced rather than marginalized. This empathetic approach fosters inclusion and a sense of belonging for all community members.

Advocacy for Resources

One of the critical implications drawn from this research is the need for communities to advocate for the availability of mental health resources. This can include things like crisis hotlines and self-help materials. These advocacy efforts are essential to ensure that individuals living with bipolar disorder have access to a comprehensive support system that extends beyond faith-based organizations.

Awareness and Resource Campaigns

Communities can actively engage in awareness campaigns to highlight the importance of mental health resources. These campaigns serve to educate residents about available crisis hotlines, self-help materials, and other support services. By disseminating information through local media, community events, and social networks, communities can ensure that individuals know the resources at their disposal.

Collaboration with Service Providers

Advocacy for mental health resources often involves collaborating with service providers and local authorities. Communities can work with mental health organizations, government agencies, and non-profit groups to secure funding and logistical support for crisis hotlines and distribute self-help materials. This collaboration helps bridge the gap between faith-based initiatives and the broader mental health ecosystem.

Support for Vulnerable Populations

Advocacy efforts should also focus on supporting vulnerable populations within the community. These include such people as low-income individuals or those with limited access to healthcare. Communities can lobby for targeted programs and resources that address the unique needs of these groups, ensuring that they, too, benefit from available crisis interventions and self-help materials.

Integration into Existing Services

To maximize the impact of advocacy, communities can explore opportunities to integrate mental health resources into existing services. For instance, local community centers, schools, and clinics can serve as distribution points for self-help materials and information about crisis hotlines. This integration ensures that individuals encounter mental health resources in various facets of their daily lives.

Crisis Hotlines as Lifelines

Advocating for crisis hotlines is particularly crucial, as they can serve as lifelines during moments of acute distress. Communities can highlight the importance of these hotlines as immediate sources of support for individuals experiencing crises related to bipolar disorder. By

advocating for well-funded and accessible crisis hotlines, communities ensure that help is just a phone call away.

Empowering Individuals to Seek Help

Ultimately, advocacy for mental health resources empowers individuals to seek help when needed. Communities can emphasize that reaching out for support is a sign of strength, not weakness. This cultural shift reduces stigma and encourages individuals with bipolar disorder to utilize crisis hotlines and self-help materials as valuable tools in their journey toward mental wellness.

In summary, the applications of this research extend to faith-based organizations, mental health services, educational institutions, and the broader community. These practical applications are essential for bridging the gap between faith and mental health. Ultimately they can improve the well-being of individuals living with bipolar disorder.

Research Limitations

This study has provided valuable insights. It leveraged the intersection of faith-based organizations and bipolar disorder. Therefore, it is essential to acknowledge several limitations that should be considered when interpreting the findings.

Sample Size and Diversity

One of the primary limitations of this research is the relatively small and homogenous sample size. The study involved eight participants, all associated with the same faith-based organization. As a result, the findings may not fully capture the diversity of perspectives and experiences within different religious communities or across various cultural backgrounds.

Future research could benefit from larger and more diverse samples to enhance the generalizability of findings.

Self-Report Bias

Another limitation stems from the nature of the data collection method, which relied on self-reported responses from participants. Self-reporting can introduce response bias, as participants may provide socially desirable answers or may not accurately represent their experiences. While efforts were made to ensure confidentiality and create a safe space for sharing, this inherent bias should be acknowledged when interpreting the qualitative responses.

Qualitative Data Depth

While qualitative data provided rich insights into participants' experiences and perceptions, the depth of data could have been further enhanced. The study's qualitative component utilized semi-structured interviews and focus groups, which may not fully capture the nuanced and complex nature of faith-based responses to bipolar disorder. Exploring additional qualitative methods, such as in-depth interviews or participant observation, could yield deeper insights.

Subjective Interpretation

Qualitative data analysis inherently involves subjective interpretation. Despite following rigorous coding procedures, there is always the potential for interpretation bias. Multiple researchers independently coded and reviewed the data to mitigate this limitation, ensuring that findings were consistent across different perspectives.

Cross-Sectional Design

This study employed a cross-sectional design, capturing participants' experiences and perspectives at a single point in time. While this approach provided valuable insights into the present, it may not capture changes or developments in attitudes and perceptions over time. Longitudinal studies could offer a more comprehensive understanding of how faith-based responses to bipolar disorder evolve.

Generalizability

It is important to recognize that the findings of this study are specific to the context in which it was conducted, within a particular faith-based organization. As such, the generalizability of these findings to other religious groups or faith-based institutions may be limited. Researchers should exercise caution when applying these findings to different contexts.

Social Desirability Bias

Participants in this study may have been influenced by social desirability bias. People may have provided responses they believed were expected or socially acceptable. This bias could affect the accuracy of their self-reported attitudes and behaviors.

Limited Quantitative Measures

The quantitative component of this study relied on a pre-test and post-test survey. It also included Likert-scale questions and paired samples t-tests. While these measures provided valuable quantitative data, they were limited in assessing the depth of participants' understanding and attitudes toward bipolar disorder.

Ethical Considerations

Ethical considerations, including informed consent and participant confidentiality, were addressed throughout the research process. However, ethical challenges may still exist. These may particularly occur in dealing with sensitive mental health and faith topics.

Recommendations for Future Research

Building upon the insights and limitations identified in this study. Several avenues for future research can further enrich our understanding of faith-based responses to bipolar disorder and related mental health conditions. These recommendations aim to guide researchers and practitioners in exploring this critical intersection in more depth and breadth:

1. **Diverse and Larger Samples:** Future research should prioritize the inclusion of more diverse and larger samples, encompassing various religious traditions, denominations, and cultural backgrounds. This approach will help uncover the nuances of faith-based responses to bipolar disorder within different contexts.
2. **Longitudinal Studies:** Investigating faith-based responses over an extended period can provide a dynamic understanding of how attitudes, perceptions, and support mechanisms evolve. Longitudinal studies can capture changes within faith communities and the impact of interventions over time.
3. **Comparative Analyses:** Comparative studies that contrast the responses of individuals from different faith backgrounds can shed light on how religious beliefs and practices influence attitudes toward bipolar disorder. These analyses can identify commonalities and distinctions among faith-based communities.
4. **In-Depth Qualitative Exploration:** While this study utilized interviews and focus groups, future research can benefit from in-depth qualitative approaches, such as

narrative analysis or ethnography. These methods can reveal the personal experiences and narratives of individuals living with bipolar disorder within faith contexts.

5. **Comparative Religious Studies:** A comparative analysis of how different religious traditions address bipolar disorder can offer valuable insights. This research can explore theological perspectives, scriptural interpretations, and religious teachings related to mental health.
6. **Effectiveness of Educational Programs:** Future research should assess the long-term effectiveness of educational programs within faith communities. Evaluating the impact of such programs on knowledge, attitudes, and support for individuals with bipolar disorder can inform best practices.
7. **Interfaith Initiatives:** Investigating interfaith initiatives and collaborations addressing mental health within faith communities can reveal strategies for bridging religious divides and enhancing support networks.
8. **Digital and Telehealth Interventions:** As technology advances, exploring the effectiveness of digital and telehealth interventions for individuals with bipolar disorder within faith contexts is crucial. These platforms can provide accessible support and resources.
9. **Global Perspectives:** Research should extend beyond specific geographic regions to offer a global perspective on faith-based responses to bipolar disorder. Comparing responses in different cultural, social, and religious contexts can uncover unique challenges and solutions.

10. **Impact of Stigma Reduction:** Studying the effects of stigma reduction campaigns within faith communities can assess changes in attitudes, perceptions, and support networks. This research can measure the effectiveness of anti-stigma interventions.
11. **Spirituality and Coping Mechanisms:** Investigating how spirituality and religious practices serve as coping mechanisms for individuals with bipolar disorder can provide insights into the role of faith in resilience and recovery.
12. **Integration of Clinical and Spiritual Care:** Research should explore models of care that integrate mental health professionals with spiritual leaders and faith-based support systems. These interdisciplinary approaches can offer holistic care.
13. **Comparative Analysis of Mental Health Literacy:** Analyzing the mental health literacy of faith-based community members compared to the general population can reveal gaps and areas for improvement.
14. **Evaluation of Mental Health Ministries:** Assessing the impact and effectiveness of mental health ministries or similar programs within faith-based organizations can provide insights into their role in supporting individuals with bipolar disorder.
15. **Community-Based Participatory Research:** Engaging faith communities actively in research design and implementation can foster a sense of ownership and collaboration. Community-based participatory research approaches can empower faith leaders and members to drive change.

These recommendations reflect the evolving landscape of faith-based responses to bipolar disorder and mental health. Addressing these research avenues will contribute to more informed, compassionate, and effective support systems within faith communities, ultimately benefiting individuals living with bipolar disorder.

Conclusion

This comprehensive research endeavor embarked on a crucial exploration of faith-based responses to bipolar disorder, recognizing the pressing need to bridge the gap between faith communities and the realm of mental health. Guided by a firm commitment to understanding, awareness, and support, this study aimed to shed light on the multifaceted interactions between faith, mental health, and individuals grappling with bipolar disorder. The conclusion revisits the research aims, scrutinizes the hypothesis, and reflects on the key findings unveiled throughout this study.

The overarching aim of this research was to investigate faith-based responses to bipolar disorder within religious communities, unraveling the complexities and dynamics that shape these responses. The research hypothesis postulated that educational programs when implemented within faith communities, could enhance knowledge and awareness of bipolar disorder, promote empathy and compassion, reduce stigma, and provide practical support to individuals living with bipolar disorder.

In pursuing these aims and scrutinizing the hypothesis, this research unfolded a rich tapestry of insights drawn from a diverse group of participants within faith-based communities. The exploration of quantitative data exposed the transformative impact of educational programs on enhancing knowledge, awareness, and compassionate responses within these communities. Paired samples t-tests underscored statistically significant improvements in participants' understanding of bipolar disorder, identification of its symptoms, awareness of church stigmas, comprehension of bipolar disorder types, recognition of biblical perspectives, grasp of sensory overload, understanding of leadership alert measures, and awareness of a leader's self-aid coping care skills. These quantitative findings laid the foundation for comprehending the nuanced landscape of faith-based responses to bipolar disorder. The qualitative phase of this study,

conducted through interviews and focus groups, further enriched our understanding. Thematic analysis illuminated six overarching themes and corresponding subthemes that encapsulated the multifaceted nature of faith-based responses to bipolar disorder.

The extensive exploration of faith-based responses to bipolar disorder leads to profound insights that carry implications for academia, faith communities, mental health practitioners, and society. This research contributes to the academic discourse by offering a nuanced understanding of faith-based responses to bipolar disorder. It underscores the importance of interdisciplinary collaboration between mental health studies and religious studies, fostering a more holistic approach to mental health care.

Faith communities can actively employ the Ministry Leaders' Educational Plan developed in this study to equip their leaders with the knowledge and empathy needed to support individuals with bipolar disorder effectively. Fostering inclusive and welcoming environments within faith-based organizations through awareness campaigns, workshops, and support groups can diminish stigma and enhance support networks. Partnerships with mental health professionals ensure comprehensive support for individuals with bipolar disorder, addressing both spiritual and clinical needs. Integrating spiritual support with clinical services can become a model of care, offering holistic support for mental health challenges. Mental health services can offer training programs for religious leaders, enhancing their understanding and supportive capabilities. Educational institutions can enhance their curricula to include mental health education, preparing future leaders to advocate for mental health within faith and community settings. Academic institutions can initiate research projects focusing on faith and mental health, contributing to the academic literature. Local organizations and individuals can work together to promote mental health literacy, reducing stigma and increasing community awareness.

Communities can advocate for the availability of mental health resources, ensuring that individuals have access to support services.

While this research journey has yielded invaluable insights, it is not without limitations. The study's focus on specific faith communities and the relatively small sample size constrains generalizability. Future research can expand horizons by considering diverse religious traditions, employing larger samples, and engaging in longitudinal studies.

In conclusion, this research explored faith-based responses to bipolar disorder, unraveling the intricate dynamics of faith, mental health, and support within religious communities. As the road ahead beckons, faith communities, mental health practitioners, and society at large are poised to embark on a collective journey toward holistic support for individuals with bipolar disorder, bridging the gap between faith and mental health, and fostering a more compassionate and informed world.

Bibliography

"3 Ways We See Jesus Display Empathy." Accessed April 7, 2023. https://www.ibelieve.com/relationships/3-ways-we-see-jesus-display-empathy.html.

"4 Types of Bipolar Disorder." Boston MindCare. 2020a. https://bostonmindcare.com/4-types-of-bipolar-disorder/.

"The Best Articles on Self-Care in the Church." When You Work for the Church. 2017. https://whenyouworkforthechurch.com/2017/01/26/the-best-articles-on-self-care-in-the-church/.

"Bipolar Disorder." Accessed Mar 18, 2023. https://www.nimh.nih.gov/health/topics/bipolar-disorder.

"Bipolar Disorder - Symptoms and Causes." Accessed Mar 24, 2023. https://www.mayoclinic.org/diseases-conditions/bipolar-disorder/symptoms-causes/syc–20355955.

"Bipolar Disorder and Low Motivation: Causes and Coping Tips." Accessed April 7, 2023. https://psychcentral.com/bipolar/i-dont-want-to-motivation-bipolar-disorder.

"Bipolar Disorder in Children and Teens." Accessed Mar 27, 2023. https://www.nimh.nih.gov/health/publications/bipolar-disorder-in-children-and-teens.

"Can You Have Both Bipolar Disorder and an Anxiety Disorder?" Accessed Mar 24, 2023. https://www.healthline.com/health/bipolar-and-anxiety.

"Disaster Preparedness, Response, and Recovery." Accessed April 29, 2023. https://www.samhsa.gov/disaster-preparedness.

Educating the Child with Bipolar Disorder. Wilmette, Illinois: Child & Adolescent Bipolar Foundation, b. https://www.dbsalliance.org/pdfs/BMPN/edbrochure.pdf.

"Getting a Handle on Stress When You have Bipolar Disorder, Part 2: The Connection Between Stress and Bipolar Disorder - International Bipolar Foundation." Accessed April 14, 2023

"Having Compassion and Being Moved to Action." Accessed April 5, 2023. https://www.compassion.com/about/what-is-compassion.htm.

"Homelessness Programs and Resources." Accessed April 29, 2023. 3. https://www.samhsa.gov/homelessness-programs-resources.

"Hope for Mental Health." Accessed April 7, 2023. https://hope4mentalhealth.com/.

"How to Help Someone with Bipolar Disorder." Accessed April 6, 2023. https://www.healthline.com/health/bipolar-disorder/caregiver-support.

"Institutional Review Board | Institutional Review Board | Liberty University." Accessed Mar 19, 2023. https://www.liberty.edu/graduate/institutional-review-board/.

"Leadership and Authority in the Church | Dwell Community Church." (h). https://dwellcc.org/learning/essays/leadership-and-authority-church.

"Motivational Leadership." Accessed April 7, 2023. https://www.ministrymagazine.org/archive/1998/10/motivational-leadership.

"NIMH Expert Dr. Mary Rooney Discusses Bipolar Disorder in Adolescents and Young Adults." Accessed Mar 20, 2023. https://www.nimh.nih.gov/news/media/2021/nimh-expert-dr-mary-rooney-discusses-bipolar-disorder-in-adolescents-and-young-adults.

"Patients & Families." Accessed April 7, 2023. https://medschool.cuanschutz.edu/psychiatry/colorado-bipolar-education-project/patients-families.

Paul Felix Lazarsfeld: Father of Research Surveys. Sogolytics Blog. 2012. https://www.sogolytics.com/blog/paul-felix-lazarsfeld-the-father-of-research-surveys/.

"RightNow Media | Streaming Video Library of Bible Studies." Accessed Mar 31, 2023. https://www.rightnowmedia.org/access-rnm?utm_source=bing&utm_medium=cpc&utm_campaign=ongoingconversions&utm_content=churchdecisionmakers&msclkid=60ee6ea9a8481fcbe35f0a8e89ab208a.

"Sensory Overload: Symptoms, Causes, and Treatment." Accessed Mar 27, 2023. https://www.medicalnewstoday.com/articles/sensory-overload.

"Supplement to Diagnostic and Statistical Manual of Mental Disorders (DSM–5) Update." (October, 2018). https://psychiatryonline.org/pb-assets/dsm/update/DSM5Update_October2018.pdf.

"Top 9 Mental Health Apps in 2022 Supported by Science." Accessed April 5, 2023. https://psychcentral.com/health/evidence-based-mental-health-apps.

"Types of Mental Health Services | Mental Health Treatment Programs." Accessed April 29, 2023. https://www.psychguides.com/mental-health-disorders/treatment/types/.

"Weekend of Faith for Mental Health." Accessed Mar 31, 2023. https://www.sumtersc.gov/news/weekend-faith-mental-health.

Behere, Prakash B., Anweshak Das, Richa Yadav, and Aniruddh P. Behere. "Religion and Mental Health." *Indian Journal of Psychiatry* 55, no. Suppl 2 (–1, 2013): S187-S194. doi:10.4103/00195545.105526. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC370568/.

Amedome, Sedem Nunyuia, and Innocent Kwame Bedi. “The Effects of Religion and Locus of Control on Perception of Mental Illness.” *Journal of Religion and Health* 58, no. 2 (April 2019): 653–65. doi:10.1007/s10943–018–0658–3.

Anyinsah, J. E. A Cooperative Inquiry: An Investigation into the Training Needs of Christian Leaders Supporting Congregants with Mental Health Issues Receiving Treatment (Order No. 28960790). Available from ProQuest Dissertations & Theses Global. (2021).

Arango, Celso, Covadonga M. Díaz-Caneja, Patrick D. McGorry, Judith Rapoport, Iris E. Sommer, Jacob A. Vorstman, and David McDaid. “Preventive Strategies for Mental Health.” The Lancet Psychiatry 5, no. 7 (2018): 591–604. doi:10.1016/S2215–0366(18)300579.

Achtemeier, Paul J., Harper’s Bible Dictionary. San Francisco: Harper & Row, 1985.

Australian Phychological Society. “Bipolar Disorder in Young People.” 34, (February, 2012). https://psychology.org.au/for-members/publications/inpsych/2012/feb/04-bipolar-disorder-in-young-people.

Baldessarini Ross, Vázquez, Gustavo, and Tondo, Leonardo. “Bipolar Depression: A Major Unsolved Challenge.” International Journal of Bipolar Disorder, 8, no. 1. (2020), 1–13.

Bechdolf, Andreas, Barnabby Nelson, Sue Cotton, Andrew Chanen, Andrew Thompson, Jonathan Kettle, Philippe Conus, Paul Amminger, Alison Yung, Michael Berk, and Patrick McGorry. “A Preliminary Evaluation of the Validity of At-Risk Criteria for Bipolar Disorders in Help-Seeking Adolescents and Young Adults.” *Journal of Affective Disorders* 127, no. 1–3 (2010): 316–320.

Bhattacherjee, Anol. “Interpretive Research.” In *Social Science Research: Principles, Methods and Practices* (Revised Edition), 2019. https://usq.pressbooks.pub/socialscienceresearch/chapter/chapter–12-interpretive-research/.

Bhimanprommachak, Vanessa. “Leading Your Team through a Crisis.” (July 20, 2020). https://www.harvardbusiness.org/leading-your-team-through-a-crisis/.

Bjørlykhaug, Knut Ivar, Bengt Karlsson, Suzie Kim Hesook, and Lise C. Kleppe. “Social Support and Recovery from Mental Health Problems: A Scoping Review.” 2022. https://www.tandfonline.com/doi/epdf/10.1080/2156857X.2020.1868553?needAccess=true&role=button.

Bloem, Steve. The Pastoral Handbook of Mental Illness: A Guide for Training and Reference. Grand Rapids, MI: Kregel Ministry, 2018.

Bornsheuer, Jennnifer, Henriksen, Richard and Beverly Irby. “Psychological Care Provided by the Church: Perceptions of Christian Church Members.” *Counseling and Values* 57, no. 2 (2012): 199–213.

Brody, Jane. “The Challenges of Bipolar Disorder in Young People.” The New York Times. July 6, 2021. https://www.nytimes.com/2021/07/05/well/mind/bipolar-disorder-young-people.html.

Burlaka, Viktor, Yi Jin Kim, Na Youn Lee, Michael Kral, and Jun Sung Hong. “Suicidal Behaviors Among College Students at a Bible Belt University: The Role of Childhood Trauma, Spirituality, Anxiety, and Depression.” *Best Practice in Mental Health* 16, no. 2 (Fall 2020): 1–20. https://search.ebscohost.com/login.aspx?direct=true&db=ofm&AN=147164288&site=ehost-live&scope=site.

Byrley, Chris. “Sickness and Disability.” *Lexham Theological Wordbook*. Edited by Douglas Mangum et al., Bellingham, WA: Lexham Press, 2014.

Cachiaras, Ben. “What Should the Church Do about the Mental Health Crisis?” Christian Standard. (2022). https://christianstandard.com/2022/07/what-should-the-church-do-about-the-mental-health-crisis/.

Cadigan, Jennifer M, Christine M Lee, and Mary E Larimer. “Young Adult Mental Health: A Prospective Examination of Service Utilization, Perceived Unmet Service Needs, Attitudes, and Barriers to Service Use.” *Prevention Science: The Official Journal of the Society for Prevention Research* 20, no. 3 (April 2019): 366–76. doi:10.1007/s11121–018–0875–8.

Caitlin, Yee, et al. “Maintenance Pharmacological Treatment of Juvenile Bipolar Disorder: Review and Meta-Analyses.” *International Journal of Neuropsychopharmacology*, 22 no. 8, (2019), 532.

Campbell, Anthony David. “Clergy Perceptions of Mental Illness and Confronting Stigma in Congregations.” *Religions* 12, no. 12 (2021): 1110. https://go.openathens.net/redirector/liberty.edu?url=https://www-proquest-com.ezproxy.liberty.edu/scholarly-journals/clergy-perceptions-mental-illness-confronting/docview/2612835349/se–2.

Campbell, Rosalyn Denise, and Tenesha Littleton. “Mental Health Counselling in the Black American Church: Reflections and Recommendations from Counsellors Serving in a Counseling Ministry.” *Mental Health, Religion & Culture* 21, no. 4 (2018): 336–352.

Cantor Jonathan, Christopher Whaley, Bradley Stein, and David Powell. “Analysis of Substance Use Disorder Treatment Admissions in the US by Sex and Race and Ethnicity Before and During the COVID–19 Pandemic.” *JAMA Network Open*, 5 no. 9 (2022), :10.1001/jamanetworkopen.2022.32795.

C. D. Dolph, “Bipolar Disorder.” *Baker Encyclopedia of Psychology & Counseling*. Edited by David G. Benner and Peter C. Hill. Grand Rapids, MI: Baker Books, 1999.

Chan, Joe Kwun Nam, CoCo Ho Yi Tong, Corine Sau Man Wong, Eric Yu Hai Chen, and Wing Chung Chang. “Life Expectancy and Years of Potential Life Lost in Bipolar Disorder:

Systematic Review and Meta-analysis." *The British Journal of Psychiatry* 221, no. 3 (2022): 567–576. doi:10.1192/bjp.2022.19.

Church, M., S. Ellenbogen, and A. Hudson. "Perceived Barriers to Accessing Mental Health Services for Rural and Small City Cape Breton Youth." *Social Work in Mental Health* 18, no. 5 (September 2020): 1–16. doi:10.1080/15332985.2020.1801553.

Cook, Christopher. "Mental Health in the Kingdom of God," *Theology*, 123, no. 3 (2020): 163–171. https://doi.org/10.1177/0040571X20910700.

Cruz, Mario, Pincus, Harold Alan, Deborah Welsh, Devra Greenwald, Elaine Lasky, and Amy Kilbourne. "The Relationship between Religious Involvement and Clinical Status of Patients with Bipolar Disorder." *Bipolar Disorders* 12, no. 1 (2010): 68–76.

De Azambuja Farias, Clarisse, de Azevedo Cardoso, Mondin Taiane, Thaise Campos, Luiciano Dias de Mattos Souza, Ricardo Azevedo da Silva, and Flavio Kapczinski. "Clinical Outcomes and Childhood Trauma in Bipolar Disorder: A Community Sample of Young Adults." *Psychiatry Research*, 275 (2019): 228–232.

Denman, Barbara. "SBC Addresses Mental Health Issues." September 1, 2013. https://www.baptistpress.com/resource-library/sbc-life-articles/sbc-addresses-mental-health-issues/.

Dome, Peter, Zoltan Rilmer, and Xenia Gonda. "Suicide Risk in Bipolar Disorder: A Brief Review." *Medicine (Kaunas)* 55, no. 8 (2019): 403–412.

Doran Kelly, Callan Elswick Fockele, and Marcella Maguire. "Overdose and Homelessness—Why We Need to Talk About Housing." *JAMA Network Open*, 5, no. 1 (2022): 1001/jamanetworkopen.2021.42685.

Fahmy, Dalia. "7 Facts about Southern Baptists." Last modified June 7, 2019. https://www.pewresearch.org/fact-tank/2019/06/07/7-facts-about-southern-baptists/.

Feeney, Brooke C., and Nancy L. Collins. "A New Look at Social Support: A Theoretical Perspective on Thriving Through Relationships." *Personality and Social Psychology Review* 19, no. 2 (2015): 113–147.

Ferrari, Alize, Emily Stockings, Joh-Paul Khoo, Holly Erskine, Louisa Degenhardt, Theo Vos, and Havery Whiteford. "The Prevalence and Burden of Bipolar Disorder: Findings from the Global Burden of Disease Study 2013." *Bipolar Disorders* 18, no. 5 (2016): 440–450.

Foley, Kate. "Ministry and Bipolar Behavior: Finding Hope in Christian Counseling." (April 30, 2021). https://millcreekchristiancounseling.com/ministry-and-bipolar-behavior-finding-hope-in-christian-counseling/.

Geddes, John and David Miklowitz. "Treatment of Bipolar Disorder." *The Lancet* 381, no. 9878 (2013): 1672–1682.

Gilbert, Paul, Jaskaran K. Basran, Joanne Raven, Hannah Gilbert, Nicola Petrocchi, Simone Cheli, and Andrew Rayner. “Compassion Focused Group Therapy for People with a Diagnosis of Bipolar Affective Disorder: A Feasibility Study.” *Frontiers in Psychology* 13, (–7–20, 2022): 841932. doi:10.3389/fpsyg.2022.841932.

Goldstein, Tina, Fersch-Podrat, Rachael, Azelson, David, Gilbert, Alison, Hlastala, Stefanie, Birmaher, Boris and Ellen Frank. “Early Intervention for Adolescents at High Risk for the Development of Bipolar Disorder: Pilot Study of Interpersonal and Social Rhythm Therapy (IPSRT*).*” *Psychotherapy* (Chic), 51, no. 1 (2014): 180–189.

Grace Theological Seminary. “Mental Health, and the Church.” Last modified, November 1, 2021. https://seminary.grace.edu/mental-health-and-the-church/.

Grand Rapids Theological Seminary of Cornerstone University. “Resilience: Finding Wholeness in Ministry by Way of the Cross.” (2020). https://www.cornerstone.edu/wp-content/uploads/2021/01/GRTS-Talking-Points-Self-Care-in-Ministry-Facilitator-Guide.pdf.

Grcevic, Stephen. *How Might Bipolar Disorder Affect Church Participation and Spiritual Development?* Church4EveryChild. 2010. https://church4everychild.org/2010/08/18/how-might-bipolar-disorder-affect-church-participation-and-spiritual-development–2/.

Hansen, G. Walter *Galatians*. *The IVP New Testament Commentary Series.* Downers Grove, IL: InterVarsity Press, 1994.

Harvard Medical School. “National Comorbidity Survey.” August 21, 2017, https://www.hcp.med.harvard.edu/ncs/index.php.

H. D. M. Spence-Jones, ed., *Genesis*. Vol. 1, *The Pulpit Commentary*. London; New York: Funk & Wagnalls Company, 1909.

Hays, Krystal. “Reconceptualizing Church-Based Mental Health Promotion with African Americans: A Social Action Theory Approach.” *Journal of Religion & Spirituality in Social Work: Social Thought* 37, no. 4 (2018): 351–372.

Henderson-Espinoza, Robyn. “The Silent Stigma of Mental Illness in the Church.” Accessed Mar 18, 2023. https://sojo.net/articles/silent-stigma-mental-illness-church.

Jaiswal, Sarvesh. Communication Skills for Effective Leadership | Emeritus India. Emeritus - Online Certificate Courses | Diploma Programs. 2022. https://emeritus.org/in/learn/why-are-communication-skills-necessary-for-good-leadership/.

Jawad, Ibrahim, Stuart Watson, Peter M. Haddad, Peter S. Talbot, and R. Hamish McAllister-Williams. “Medication Nonadherence in Bipolar Disorder: A Narrative Review.” *Therapeutic Advances in Psychopharmacology* 8, no. 12 (2018): 349–363.

Jennifer Cadigan, Christine M Lee, and Mary E Larimer. “Young Adult Mental Health: A Prospective Examination of Service Utilization, Perceived Unmet Service Needs, Attitudes, and Barriers to Service Use.” *Prevention Science: The Official Journal of the Society for Prevention Research* 20, no. 3 (April 2019): 366–76. doi:10.1007/s11121–018–0875–8.

John Peter Lange and Philip Schaff. *A Commentary on the Holy Scriptures: Matthew*. Bellingham, WA: Logos Bible Software, 2008.

Jones, Michael R. “Teaching.” *Lexham Theological Wordbook.* Edited by Douglas Mangum et al. Bellingham, WA: Lexham Press, 2014.

Katzman, Martin, Timothy Milkey, Pratap Chokka, Angelo Fallu, and Larry Klassen. “Adult ADHD and Comorbid Disorders: Clinical Implications of a Dimensional Approach.” *BMC Psychiatry*, 17 (2017): 1–15.

Koenders, M. A., E. J. Giltay, A. T. Spijker, E. Hoencamp, P. Spinhoven, and B. M. Elzinga. “Stressful Life Events in Bipolar I and II Disorder: Cause or Consequence of Mood Symptoms?” *Journal of Affective Disorders* 161, (Jun 1, 2014): 55–64. doi:10.1016/j.jad.2014.02.036.

Kort-Butler, Lisa. *Social Support Theory*. John Wiley and Sons, 2018.

Latifian, Maryam, Ghoncheh Raheb, Riaz Uddin, Kianoush Abdi, and Rosa Alikhani. “The Process of Stigma Experience in the Families of People Living with Bipolar Disorder: A Grounded Theory Study.” *BMC Psychology* 10, no. 1 (2022): 1–12.

Lloyd, Christopher E. M., and Jonathan Hutchinson. “It is Easy to Dismiss it as Simply a Spiritual Problem. Experiences of Mental Distress within Evangelical Christian Communities: A Qualitative Survey.” *Transcultural Psychiatry* (2022): 13634615211065869.

Loots, Elke, Eva Goossens, Toke Vanwesemael, Manuel Morrens, Bart Van Rompaey, and Tinne Dilles. “Interventions to Improve Medication Adherence in Patients with Schizophrenia or Bipolar Disorders: A Systematic Review and Meta-Analysis.” *International Journal of Environmental Research and Public Health* 18, no. 19 (2021): 10213.

Maccoby, Michael. “Why People Follow the Leader: The Power of Transference.” *Harvard Business Review* (–09–01T04:00:00Z, 2004). https://hbr.org/2004/09/why-people-follow-the-leader-the-power-of-transference.

Magazine, bp. 8 Things Every Teacher Should Know about Bipolar Disorder. bpHope.Com. 2016. https://www.bphope.com/kids-children-teens/8-things-every-teacher-should-know-about-bipolar-disorder/.

Manhas, Rameshwar S., Gaurav S. Manhas, Angli Manhas, Rishabh Sharma, Jagdish R. Thappa, and Rukhsana Akhter. “Prevalence of Non-Adherence to Treatment Among Patients of

Bipolar Affective Disorder." *Journal of Medical Science and Clinical Research* 7, no. 6 (2019): 623–628.

Marshall, Paul, Steven Jones, Patricia Gooding, Heather Robinson, and Fiona Lobban. "Caring for a Family Member with Psychosis or Bipolar Disorder Who Has Experienced Suicidal Behaviour: An Exploratory Qualitative Study of an Online Peer-Support Forum." *International Journal of Environmental Research and Public Health* 19, no. 22 (2022): 15192.

McLellan Thomas. Substance Misuse and Substance Use Disorders: Why Do They Matter in Healthcare? *Transactions of The American Clinical and Climatological Association,* 128, (2017): 112–130.

Merikangas, Kathleen, Robert Jin, Jian-Ping He, Ronald Kessler, and Zahari Zarkov. "Prevalence and Correlates of Bipolar Spectrum Disorder in the World Mental Health Survey Initiative." *Arch Gen Psychiatry* 68, no. 3 (2011): 241–251.

Miklowitz, David. "Family Treatment for Bipolar Disorder and Substance Abuse in Late Adolescence." *Journal of Clinical Psychology*, 68, no. 5 (2012): 502–513.

Miller, Jacob N., and Donald W. Black. "Bipolar Disorder and Suicide: A Review." *Current Psychiatry Reports* 22 (2020): 1–10.

Momen, Natalie C., Oleguer Plana-Ripoll, Esben Agerbo, Maria K. Christensen, Kim Moesgaard Iburg, Thomas Munk Laursen, and Preben B. Mortensen. "Mortality Associated with Mental Disorders and Comorbid General Medical Conditions." *Archives of General Psychiatry* 79, no. 5 (May 1, 2022): 444–453. doi:10.1001/jamapsychiatry.2022.0347.

Morse, Janice M. "The Significance of Saturation." *Qualitative Health Research* 5, no. 2 (–05–01, 1995): 147–149. doi:10.1177/104973239500500201.

Nadkarni, Radha B., and Mary A. Fristad. "Stress and Support for Parents of Youth with Bipolar Disorder." *The Israel Journal of Psychiatry and Related Sciences* 49, no. 2 (2011): 104. Accessed November 24, 2022. https://doi.org/https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4348006/.

National Institute of Mental Health. "Bipolar Disorder," NIMH, 3, no. 2(2022): 401–406.

Noel Clavecilla, Noel. *The Anatomy of Church Leaders.* Eugene: Wipf and Stock Publishers, 2020.

Owen, Rebecca, Steven H. Jones, Robert C. Dempsey, and Patricia A. Gooding. "Directly or Idirectly? The Role of Social Support in the Psychological Pathways Underlying Suicidal Ideation in People with Bipolar Disorder." *International Journal of Environmental Research and Public Health* 19, no. 9 (2022): 5286.

Pakpour, Amir H., Amirhossein Modabbernia, C-Y. Lin, Mohsen Saffari, M. Ahmadzad Asl, and Thomas L. Webb. "Promoting Medication Adherence Among Patients with Bipolar

Disorder: A Multicenter Randomized Controlled Trial of a Multifaceted Intervention." *Psychological Medicine* 47, no. 14 (2017): 2528–2539.

Peters, Chuck. "5 Leadership Lessons from Gideon." Accessed April 6, 2023. https://voices.lifeway.com/church-ministry-leadership/5-leadership-lessons-from-gideon/.

Pew Research Center. "Adults in South Carolina." Last modified 2022. https://www.pewresearch.org/religion/religious-landscape-study/state/south-carolina/

Post, Robert, Altshuler, Lori, Kupka Ralph, McElroy, Susan, Frye, Mark, Rowe, Michael, Grunze, Heinz, Suppers, Trisha, Keck, Paul and Willem Nolen. "More Childhood Onset Bipolar Disorder in the United States than Canada or Europe: Implications for Treatment and Prevention." *Neuroscience & Biobehavioral Reviews* 74 (2017): 204–213.

Prior, Laura, Lioret, Sandrine, van der Waerden, Judith, Fombonne, Eric, Falissard, Bruno and Maria Melchior. "Food Insecurity and Mental Health Problems Among a Community Sample of Young Adults." *Social Psychiatry and Psychiatric Epidemiology* 51 (2016): 1073–1081.

Proudfoot, Judith, Whitton, Alexis, Parker, Gordon, Doran, Justin, Manicavasagar, Vijaya and Kristy Delmas, "Triggers of Mania and Depression in Young Adults with Bipolar Disorder." *Journal of Affective Disorders* 143, no. 1–3 (2012): 196–202.

Rantala, Markus, Luoto, Severi, Borraz-Leon, Javier and Indrikis Krams. "Bipolar Disorder: An Evolutionary Psychoneuroimmunological Approach." *Neuroscience & Biobehavioral Reviews* 122 (2021): 28–37.

Reupert, Andrea, Brenda Gladstone, Rochelle Helena Hine, Scott Yates, Violette McGaw, Grant Charles, Louisa Drost, and Kim Foster. "Stigma in Relation to Families Living with Parental Mental Illness: An Integrative Review." *International Journal of Mental Health Nursing* 30, no. 1 (2021): 6–26.

Reynolds, Mildred M. "Religious Institutions and the Prevention of Mental Illness." *Journal of Religion and Health* 21, no. 3 (1982): 245–253. http://www.jstor.org/stable/27505686.

Roach, David. "Count the Faces: SBC Diversity on the Rise." Last modified June 11, 2021. https://www.baptistpress.com/resource-library/sbc-life-articles/count-the-faces-sbc-diversity-on-the-rise/.

Robinson, Michael, Jones-Eversley, Sharon, Moore, Sharon, Ravenell, Joseph and Christon Adedoyin. "Black Male Mental Health and the Black Church: Advancing a Collaborative Partnership and Research Agenda." *Journal of Religion and Health* 57 (2018): 1095–1107.

Roosa, Tikkanen, et al. Mental Health Conditions and Substance Use: Comparing U.S. Needs and Treatment Capacity with Those in Other High-Income Countries. *The Commonwealth Fund.* https://www.commonwealthfund.org/publications/issue-briefs/2020/may/mental-health-conditions-substance-use-comparing-us-other-countries.

Rosenberg, Linda. “Behavioral Disorders: The New Public Health Crisis.” *The Journal of Behavioral Health Services & Research* 39, no. 1 (–01, 2012): 1–2. doi:10.1007/s11414–011–9265–8.

Rowland Tobias and Steven Marwaha. “Epidemiology and Risk Factors for Bipolar Disorder.” *Ther Adv Psychopharmacol*, 8, no. 9, (2018), 251–269 DOI: https://doi.org/10.1177/2045125318769

Saxton, Kevin Bryce. “Family Ministry and Evangelism: An Empirical Study of Family Ministry Engagement and Baptism Ratios in the Southern Baptist Convention.” Ph.D. dissertation (The Southern Baptist Theological Seminary, 2017).

Seminary, Grace T. “Mental Health and the Church.” Accessed Mar 18, 2023. /mental-health-and-the-church/.

Sensing, Tim. Qualitative Research: A Multi-Methods Approach to Projects for Doctor of Ministry Theses (Eugene, OR: Wipf & Stock, 2011).

Shamsaei, Fashid, Kermanshahi, Sima Mohamad Khan, Vanaki, Zohreh, and Martin Grosse Holtforth. “Family Caregiving in Bipolar Disorder: Experiences of Stigma.” *Iranian Journal of Psychiatry* 8, no. 4 (2013): 188–194.

Smith Causey, Ivory. “Coping with Bipolar Disorder within My Faith Community | NAMI: National Alliance on Mental Illness.” (July 15, 2019). https://www.nami.org/Blogs/NAMI-Blog/July–2019/Coping-with-Bipolar-Disorder-within-My-Faith-Community.

Smith, Craig A. “Church Leadership.” *Lexham Theological Wordbook*. Edited by Douglas Mangum et al. Bellingham, WA: Lexham Press, 2014.

Smith, Emma-Marie. “Bipolar Facts and Statistics: Bipolar Disorder is Real.” *HealthyPlace*. Last modified December 28, 2021. Accessed November 24, 2022. https://www.healthyplace.com/bipolar-disorder/bipolar-information/bipolar-facts-and-statistics-bipolar-disorder-is-real.

Sogutlu, Lutfiye, Cenk Varlik, Ahmet Guler, Yildiz Bilge, and Seyyide Sifa Goktas. “The Effectiveness of Family Psychological Training Program Applied to Relatives of Patients with Schizophrenia.” *Psychiatria Danubina* 33, no. 4 (2021): 551–559.

Stroud, Clare, Walker, Leslie, Davis Maryann, and Charles Irwin. “Investing in the Health and Well-Being of Young Adults.” *Journal of Adolescent Health* 56, no. 2 (2015): 127–129.

Sulley, Saanie, Ndanga Memory, and Nana Mensah. “Pediatric and Adolescent Mood Disorders: An Analysis of Factors that Influence Inpatient Presentation in the United States.” *International Journal of Pediatrics and Adolescent Medicine* 9, no. 2, (2022), 89–97.

Sullivan, Aimee, Charles Judd, David Axelson, and David Milkowitz. “Family Functioning and the Course of Adolescent Bipolar Disorder.” *Behavior Therapy* 43, no. 4 (2012): 837–847.

Tikkanen, Roosa, Katharine Fields, Reginald D. Williams II, and Melinda K. Abrams. “Mental Health Conditions and Substance Use: Comparing U.S. Needs and Treatment Capacity with Those in Other High-Income Countries. The Commonwealth Fund.” https://www.commonwealthfund.org/publications/issue-briefs/2020/may/mental-health-conditions-substance-use-comparing-us-other-countries.

Tracy, Natasha. “Bipolar - What Does ‘I’M Sick’ Mean?” Accessed Mar 20, 2023. https://natashatracy.com/bipolar-blog/bipolar-what-im-sick-mean/.

Turton, Holly, Katherine Berry, Adam Danquah, and Daniel Pratt. “The Relationship Between Emotion Dysregulation and Suicide Ideation and Behavior: A Systematic Review.” *Journal of Affective Disorders Reports* 5 (2021): 100136.

U.S. Census Bureau. “QuickFacts Columbia City, South Carolina.” Last modified July 1, 2021, https://www.census.gov/quickfacts/columbiacitysouthcarolina

Vision of Humanity. “Defining the Concept of Peace.” Accessed April 5, 2023. https://www.visionofhumanity.org/defining-the-concept-of-peace/.

Viktor, Burlaka et al. “Suicidal Behaviors Among College Students at a Bible Belt University: The Role of Childhood Trauma, Spirituality, Anxiety, and Depression,” *Best Practice in Mental Health* 16, no. 2 (Fall 2020): 1–20. https://search.ebscohost.com/login.aspx?direct=true&db=ofm&AN=147164288&site=ehost-live&scope=site.

Weir, Kirsten. "Reaching Out to the Faithful." Accessed Oct 27, 2023. https://www.apa.org/monitor/2020/04/reaching-faithful.

Wessa, Michèle, Julia Linke, Michèle Wessa, and Julia Linke. “Emotional and Motivational Processes in Bipolar Disorder: A Neural Network Perspective.” IntechOpen, 2013. doi:10.5772/51890. https://www.intechopen.com/chapters/44829.

Weston, Mark. *Creating a Church Counselling Ministry*. Scotts Valley: CreateSpace Independent Publishing Platform, 2016.

Williams, Laverne, Gorman, Robyn, and Sidney Hankerson. “Implementing a Mental Health Ministry Committee in Faith-Based Organizations: The Promoting Emotional Wellness and Spirituality Program.” *Social Work in Health Care* 53, no. 4 (2014): 414–434.

Yee Caitlin, Emily Hawken, Ross Baldessarini, and Gustavo Vázquez. “Maintenance Pharmacological Treatment of Juvenile Bipolar Disorder: Review and Meta-Analyses.” *International Journal of Neuropsychopharmacology*, 22 no. 8, (2019), 531–540.

Appendix A

Permission Request

March 19, 2023

[redacted]
Pastor
[redacted] Church
[redacted]
Columbia SC [redacted]

Dear Pastor [redacted],

As a graduate student in the Doctor of Ministry program at Liberty University, I am conducting a project as part of the requirements for a doctorate. The title of my project is Assisting Ministry Leaders Managing Bipolar Disorder in Adolescents and Young Adults. My project aims to design and implement a customized educational program for ministry leaders leading individuals with bipolar disorders.

I request your permission to invite church ministry leaders to participate in the project.

Participants will be asked to complete the attached survey and presented with informed consent information before participating. Participating in this project is entirely voluntary, and participants are welcome to discontinue participation at any time.

Liberty University permission should be on an approved letterhead with the appropriate signature(s) for educational research. Thank you for considering my request. If you grant permission, please provide a signed statement on official letterhead indicating your approval or email [redacted] Attached is a permission letter document for your convenience.

Sincerely,

La'Shanna Williams
Doctoral Candidate

Appendix B

Permission Response

Permission Response

April 27, 2023

[redacted]
Pastor
[redacted]

Dear La'Shanna Williams,

After carefully reviewing the research proposal entitled Assisting Ministry Leaders Managing Bipolar Disorder in Adolescents and Young Adults, I have agreed to let you contact our ministry leaders and invite them to participate in the project.

Check the following boxes, as applicable:

☑ I will provide our ministry leaders list to La'Shanna Williams, and she may use it to contact our ministry leaders to invite them to participate in her research project.

☑ I grant permission for La'Shanna Williams to contact ministry leaders to invite them to participate in her project.

☑ I will not provide potential participant information to La'Shanna Williams, but we agree to send her project information to the ministry leaders.

Sincerely,

[redacted]
Pastor
[redacted]

Permission Request Inbox ×

[redacted]
to me

Here you go. You have my permission. :)

[redacted]

[redacted]
Lead Pastor, [redacted]

[redacted]

One attachment • Scanned by Gmail

Appendix C

Informed Consent

Title of the Project: Assisting Ministry Leaders Managing Bipolar Disorder in Adolescents and Young Adults

Principal Investigator: La'Shanna Williams, Liberty University Doctoral Candidate

Here is an invitation to participate in a project. Participants must be a member of Love Faith Church, ministry leaders, and over 18. Participation in this project is voluntary.

Before participating in this project, please read the entire form and ask questions.
The project examines ministry leaders' responses to mental health issues among adolescents and young bipolar adults at Love Faith Church. It aims to establish a framework for ministry leaders, facilitate a management style that indicates confidence, and demonstrate that biblical guidance is necessary and sufficient for addressing individual needs.

If a person agrees to participate, the researcher will ask the participants to answer the open-ended, easy-to-understand questionnaire to discover more about the participant's religious beliefs, values, and experiences.

Participating in this project may allow participants to gain insight into the religious beliefs that motivate them to lead bipolar individuals.

Understanding how ministry leaders can support individuals in a church setting might benefit the church and their families.

There will be no public disclosure of the results of this project. Keeping records secure is a priority, and only the researcher has access.

• Responses are anonymous.
• The researcher will conduct interviews in a private setting.
• Future presentations might use password-protected computer data. The researcher will delete all electronic records after three years.
• Focus groups cannot guarantee confidentiality, which is discouraged, but other focus group members may share the discussions with people outside the group.
• Recordings will be made.
• This study will compensate participants who complete the educational program with a $10 Amazon gift card.
• There is no cost to participate in the project.

The participant is a volunteer in this project. The decision of the participant to participate will not impact Liberty University's current or future relationships. Before submitting the questionnaire, participants can withdraw without answering any questions.

The researcher can be reached at the email address or phone number in the next paragraph if a participant decides to withdraw from the project. Withdrawing participants will have their data destroyed immediately and not used.

The researcher conducting this project is La'Shanna Williams. The participants may ask any questions they have now. If the participant has questions later, they are encouraged to contact her at [redacted]

The participant may also contact the researcher's faculty sponsor, Dr. David Barnett, at [redacted]

If there are any questions or concerns regarding this project and want to talk to someone other then the researcher participants are encouraged to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515, or email irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) ensures that human subjects' research will be conducted ethically as defined and required by federal regulations. The topics covered, and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

It is essential to understand the project before agreeing to be a part of it. Participants will receive a copy of this document for their records. Use the information above to contact the researcher with additional questions about the project.

_____

Printed Subject Name

_____

Signature & Date

_____

Email

Appendix D

Confidentiality Statement

The Ministry Leaders Educational Program, Assisting Ministry Leaders Managing Bipolar Disorder in Adolescents and Young Adults project is committed to protecting the privacy and confidentiality of our participants. The researcher will not share the participant's personal information with anyone outside the educational program without the participant's permission. However, if the participant shares material during the focus group meetings, other participants may learn the name and information the participant shares with the group.

To maintain confidentiality, the researcher asks participants not to share other participants' names or personal information outside of the educational program. The researcher also asks the participants not to record any of the educational program sessions without the prior written permission of the program.

Do not hesitate to contact the researcher with any questions or concerns about confidentiality.

By signing this form, the participant confirms reading and understanding of the confidentiality statement above.

Participant Signature: _____ Date: _____

Appendix E

Screening Survey

Title of the Project: Assisting Ministry Leaders Managing Bipolar Disorder in Adolescents and Young Adults

Principal Investigator: La'Shanna Williams, Liberty University, Doctoral Candidate

Age: (Choose One)
• 18–25
• 26–33
• 34–40
• 41 and older

Race: (Choose One)
• White or Caucasian
• African or Black.
• American Indian or Alaska Native
• Latino or Hispanic
• Asian
• Pacific Islander or Hawaiian
• Prefer not to answer

Highest Level of Education: (Choose One)
• No diploma or High School equivalence
• High School Graduate
• Some College
• Associate's degree
• Bachelor's degree
• Master's degree
• Doctorate
• Other _____

Length of Time Affiliated with the Church: (Choose One)
• 0–2 Years
• 2–3 Years
• 3–5 Years
• 5+ Years

Ministry Department (Choose One)
• Worship Ministry
• Prayer Ministry
• Life Group Ministry
• Youth Ministry
• Other _____

Appendix F

Survey Questions

Pre-Test Survey Questions (Multiple Choice Answers)

1. **What is bipolar disorder?**
    a. A severe mental disorder in which people interpret reality abnormally.
    b. People with this condition have difficulty interacting and communicating with others.
    c. Extreme mood swings that include emotional highs (mania or hypomania) and lows (depression)
    d. Describes a mental health condition caused by recurrent distress and anxiety, flashbacks, and avoiding similar situations after a traumatic event.
    e. I do not know.
2. **What are some symptoms of bipolar disorder?**
    a. Reliving – flashbacks, hallucinations, nightmares of the incident
    b. They may include mania or hypomania, and depression.
    c. Obsessions are repeated, persistent and unwanted thoughts, urges, or images that are intrusive and cause distress or anxiety.
    d. An inability to communicate or interact socially and behaviors or interests that are repetitive or restricted.
    e. I do not know.
3. **What are some church stigmas surrounding bipolar disorder?**
    a. Individuals are crazy.
    b. Individuals need Jesus to rid of this disorder.
    c. Individuals can pass this disorder from human to human.
    d. Individuals are just ordinary people.
4. **How many types of bipolar disorders are there?**
    a. 0–4
    b. 5–9
    c. 10–14
    d. 15 or more
    e. I do not know.
5. **Who are some biblical figures that can give biblical perspectives about special needs?**
    a. David, Elijah, Jonah, Moses, Jeremiah, Jesus
    b. Solomon, Samuel, Enoch, Adam, Elisha, Joshua
    c. Rebecca, Noah, Cain, Boaz, Gad, Matthew
    d. Isaiah, Isaac, Mordecai, Tamar, Adah, Abel
    e. I do not know.
6. **What are some examples of sensory overload?**
    a. Hormonal changes
    b. Certain sounds, sights, smells, or tastes
    c. Cell phones, video games, social media outlets
    d. Walking, meditating, and yoga.
    e. I do not know.

7. **What are some examples of leadership alert measures with individuals?**

a. Have a plan, flexibility, few distractions, and practice patience.
b. Play music, binge Netflix, sit, and rest
c. Do homework, write a book, and play family games.
d. Time out, sleep, drink water, and rest
e. I do not know.

8. **What are some examples of a leader's self-aid coping care skills?**
    a. They participate in activities that provide instant gratification
    b. Spiritual, Physical, Psychological, Socio-Emotional, and Workplace or Professional Self-Care
    c. Going on expensive and lavish vacations
    d. Binge-watching television
    e. I do not know.

Post-Test Survey Questions (Likert Scale)

9. **This Educational Program improved participants' skill levels when leading adolescents with bipolar disorder and young adults with bipolar disorder.**
    a. Strongly Agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly Disagree
10. **This Educational Program identified bipolar disorder symptoms.**
    a. Strongly Agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly Disagree
11. **This Educational Program reviewed some church stigmas surrounding bipolar disorder.**
    a. Strongly Agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly Disagree
12. **This Educational Program discussed four types of bipolar disorders.**
    a. Strongly Agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly Disagree

13. This Educational Program helped the participants identify biblical principles that give perspectives on special needs.
    a. Strongly Agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly Disagree

14. This Educational Program gives some examples of sensory overload to participants.
    a. Strongly Agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly Disagree

15. This Educational Program improved the participant's understanding of leadership alert measures.
    a. Strongly Agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly Disagree

16. This Educational Program brings awareness to a leader's self-aid coping care skills.
    a. Strongly Agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly Disagree

Appendix G

Interview Questions

Interview Questions: (Please describe or explain answers)

1. How would you define mental health?
2. What is your understanding of bipolar disorder?
3. What symptoms do you recognize in bipolar disorder?
4. What biblical passages can you refer to when communicating with adolescents and young adults with bipolar disorder in your ministry?
5. What are the many symptoms of bipolar disorder?
6. What can you do when adolescents and young adults show signs of anxiety, panic, or difficulty concentrating on helping them?
7. What are some of the church's responses when adolescents and young adults have a mental breakdown?
8. How would you like to see this situation from you as the ministry leader in this crisis?
9. How would you like the problem handled instead in your ministry?
10. How can bipolar disorder issues be addressed through programs and tools in your ministry?
11. What church strategies are in place to help adolescents and young adults feel comfortable approaching ministry leaders?
12. How can you manage adolescents and young adults with bipolar disorders as a ministry leader?
13. How do you hope this educational program will benefit you as a ministry leader?
14. How can you, as a ministry leader, contribute to achieving these hopes now and in the future?
15. Describe how you can recommend resources to help adolescents and young adults in your ministry.

Appendix H

Focus Group Questions

Focus Group Questions:

1. Describe when you witnessed, discussed, or heard someone mention an adolescent or young adult with bipolar disorder.
2. In response to the situation, how did you react or think?
3. What would you do if you encountered the situation in the context of the church setting?
4. Describe a situation when an adolescent or young adult acted out, appeared uninterested, was irritable, or impulsive in the church setting.
5. As a result of the situation, what were the steps you took as the ministry leader?
6. A ministry leader faces specific barriers when working with these adolescents and young adults in a church setting. What are some of these barriers?
7. Provide an overview of the resources available to these adolescents and young adults from the church.
8. How many leadership steps exist for the church to gain knowledge of these adolescents and young adults?

Appendix I

Debriefing Statement

Title of the Project: Assisting Ministry Leaders Managing Bipolar Disorder in Adolescents and Young Adults

Principal Investigator: La'Shanna Williams, Liberty University, Doctoral Candidate

You recently participated in a project. You were selected as a participant because you met the eligibility criteria, age, race, education, length of time affiliation, and ministry role within the church. Participation in this project was voluntary.

Please read this entire form and ask any questions you may have.

Participating in this project may allow participants to gain insight into the religious beliefs that motivate them to lead bipolar individuals. The project examines ministry leaders' responses to bipolar disorder issues among adolescents and young bipolar adults at Love Faith Church. It aims to establish a framework for ministry leaders, facilitate a management style that indicates confidence, and demonstrate that biblical guidance is necessary and sufficient for addressing individual needs.

Your data may be shared in future project studies or with other researchers. If data collected from you is shared, any information that could identify you, if applicable, will be removed before transferring data.

There will be public disclosure of the results of this project. Keeping records secure is a priority, and only the researcher has access.
• Responses are anonymous.
• The researcher will conduct interviews at a private location.
• Future presentations might use password-protected computer data. The researcher will delete all electronic records after three years.
• Focus groups cannot guarantee confidentiality. Other focus group members may share the discussions with people outside the group, but it is discouraged.
• Recordings will be made.
• This project will compensate participants.
• There is no cost to participate in the project.

The researcher can be reached at the email address or phone number in the next paragraph if a participant decides to withdraw from the project. Withdrawing participants will have their data destroyed immediately and not used.

The researcher conducting this project is La'Shanna Williams. The participants may ask any questions they have now. If the participant has questions later, they are encouraged to contact her at [redacted]

The participant may also contact the researcher's faculty sponsor, Dr. David Barnett, at [redacted]

If there are any questions or concerns regarding this project and want to talk to someone other Then, the researcher participants are encouraged to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515, or email irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) ensures that human subjects' research will be conducted ethically as defined and required by federal regulations. The topics covered, and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Appendix J

Educational Program Layout

Week 1: Ministry Leaders' Introduction to Bipolar Disorder

What is Bipolar Disorder?

Bipolar disorder is so named because those afflicted with it experience both mania and depression, unlike those with unipolar disorders, who experience only one extreme, usually depression. There are two types of bipolar disorders, Bipolar I and Bipolar II; Bipolar I experiences both mania and depression; in Bipolar II, the individual experiences hypomania and depression. Mania or hypomania is the key to diagnosing bipolar disorder. A person who experiences a manic state even once is presumed to have bipolar disorder. Individuals with bipolar disorder may undergo more episodes of depression than manic episodes, and they may have long intervals between attacks of each. Some individuals, known as rapid cyclers, experience four or more episodes yearly.[1]

Bipolar Amongst Adolescents and Young Adults

Recent studies indicate that bipolar illnesses are a widespread concern worldwide. According to Cook, common mental conditions affect 20 percent of adults worldwide, while between 1 and 7 percent of adults suffer from severe cases of these disorders.[2] The author adds that 10 to 20 percent of adolescents and children report mental disorders, with most issues beginning at 14.[3] With one in every five adults having mental conditions, these disorders represent a significant public concern worldwide. Additionally, 10 to 20 percent of adolescents and children reporting mental disorders reveal the widespread mental conditions in adults and the growing population. Nevertheless, young people exhibit more signs of these bipolar conditions than adults.

The U.S. has a considerably high prevalence of bipolar disorders among older adolescents and young adults. While citing a 2019 World Health Organization report, Burlaka et al. observed that suicide, one of the signs of bipolar disorder, is a leading cause of death among young adults and late adolescents in the U.S., with 16 percent of this group reporting suicide ideation or suicide attempt.[4] Additionally, Cadigan, Lee, and Larimer estimate that 22 percent of U.S. youths meet the requirements for a mental health condition,

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[1] C. D. Dolph, "Bipolar Disorder," ed. David G. Benner and Peter C. Hill, *Baker Encyclopedia of Psychology & Counseling*, Baker Reference Library (Grand Rapids, MI: Baker Books, 1999), 145.

[2] Christopher Cook "Mental Health in the Kingdom of God," *Theology*, 123, no. 3 (2020), 164. https://doi.org/10.1177/0040571X20910700.

[3] Ibid.

[4] Burlaka et al. "Suicidal Behaviors Among College Students at a Bible Belt University."

with more than 2.5 million reporting mental health services in the past year.[5] With more than 7.6 million of its youth population suffering from mental illnesses and 16 percent of this group having suicide ideation or suicide attempt, the U.S. has widespread cases of mental disorders. One of these mental conditions affecting the youths is bipolar disorder.

Recent studies indicate that the U.S. has a considerably high prevalence rate of bipolar disorders. According to Rowland and Marwaha, for every 100 people, the country has a person who has bipolar disorder.[6] In their study, Sulley, Ndanga, and Mensah found that mood disorder is a leading cause of morbidity and mortality, with young people recording the highest prevalence at about 17 years.[7] Although one percent is a fraction of the total cases of mental disorders in the U.S., the figure still represents a concerning prevalence. This percentage indicates that more than 3.3 million young Americans have bipolar disorders. As one of the leading causes of illness and mortality among young people, bipolar disorder is a significant public health concern. This challenge has more pronounced effects on some races than others.

Church Stigma Around Mental Health

The lack of professional training on mental conditions limits the role of religious leaders in assisting people with bipolar disorder. According to Anyinsah, most religious leaders feel insufficiently equipped to collaborate with healthcare practitioners to treat mental challenges because they lack proper mental health literacy.[8] The author adds that these leaders are reluctant to cooperate with a hostile system.[9] Although Anyinsah conducted this study in the U.K., religious leaders in the U.S. do not undertake sufficient training programs to handle bipolar and other mental conditions. Without this knowledge, church leaders' collaboration with experienced and highly skilled medical practitioners leads to discomforting encounters for the former. Untrained religious leaders are also unpopular with some patients.

Church leaders shape cultural values and identities that help with this mental condition. According to Amedome and Bedi, various cultural and personal aspects of identity, including religious beliefs and beliefs, significantly influence individuals' early development.[10]

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[5] Jennifer Cadigan, Christine M Lee, and Mary E Larimer. "Young Adult Mental Health: A Prospective Examination of Service Utilization, Perceived Unmet Service Needs, Attitudes, and Barriers to Service Use." *Prevention Science: The Official Journal of the Society for Prevention Research* 20, no. 3 (April 2019): 366–76. doi:10.1007/s11121-018-0875-8.

[6] Tobias Rowland and Steven Marwaha. Epidemiology and Risk Factors for Bipolar Disorder. *Ther Adv Psychopharmacol*, 8, no. 9, (2018), pp. 251.

[7] Saanie Sulley, Memory, Ndanga, Nana Mensah. Pediatric and Adolescent Mood Disorders: An Analysis of Factors that Influence Inpatient Presentation in the United States. *International Journal of Pediatrics and Adolescent Medicine* 9, no. 2, (2022), 90.

[8] Anyinsah, *7*

[9] Ibid.

[10] Amedomeand and Bedi.

However, Arango notes that most bipolar conditions develop during their development because they are mentally vulnerable.[11] Due to this emotional vulnerability, ministry leaders provide them with solid beliefs that strengthen their mental capacity. By shaping the youths' identity through religious beliefs, ministry leaders play a preventive role in the fight against bipolar mental conditions. As a result, these church leaders develop the mental strength to help manage mental disorders throughout their lives. These religious leaders help adolescents and young adults address their bipolar disorders by providing emotional support during episodes.

Week 2: Symptoms of Bipolar Mental Health Disorder

Four Types of Bipolar Disorders

Individuals with bipolar disorder may experience erratic mood changes and have problems managing their daily energy levels and activities. These four types of bipolar disorder and how ministry leaders characterize them can learn more about them.

1. Bipolar 1

A manic episode can occur with or without depressive symptoms in this type of bipolar disorder. The severity of the mania will determine how long it lasts, and it may need hospitalization. There is no requirement that you have depression to be diagnosed with bipolar 1, but it may also present as depression that lasts longer than two weeks. [12]

2. Bipolar 2

The mania you experience with bipolar two disorder, also known as hypomania, is usually milder than the mania you would share with bipolar one, called manic episodes. Before or after a manic break, people with bipolar two experience a major depressive episode.[13]

3. Cyclothymic Disorder

The symptoms of the cyclothymic disorder include both manic and depressive episodes that last two years or longer. Children must experience both episodes for at least a year to be diagnosed with the condition. Usually, this disorder presents with less severe episodes of mania and depression than bipolar 1 or 2. You may experience periods of normalcy interrupted by periods of depression and mania caused by cyclothymic disorder.[14]

4. Other Types

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[11] Celso, Arango, et al. "Preventive Strategies for Mental Health." *The Lancet Psychiatry* 5, no. 7 (2018): 591-604. doi:10.1016/S2215-0366(18)30057-9. https://www.sciencedirect.com/science/article/pii/S2215036618300579.

[12] 4 Types of Bipolar Disorder. Boston MindCare. 2020a. https://bostonmindcare.com/4-types-of-bipolar-disorder/.

[13] Ibid.

[14] Ibid.

There are three types of bipolar disorder. However, if you experience symptoms that do not fit into any of them, you are considered type 4 or "other." In addition to drugs, alcohol, and underlying medical conditions, other factors can cause this type of bipolar disorder.[15]

Some Symptoms of Bipolar Disorder

In bipolar disorder episodes, moods are intense, activity levels are high, thoughts are frequent, and behaviors are erratic. There are three types of attacks that children and teens with bipolar disorder may experience: manic episodes, depressive episodes, and "mixed" episodes. There are both depressive and manic symptoms in mixed episodes. A prolonged period of symptoms is associated with these mood episodes, and an episode lasts most of the day and occurs daily. Children and teens with these mood and activity changes behave differently than healthy ones.[16]

Children and teens having **manic episodes** may[17]

- Spend prolonged periods being happy or silly.
- Have a very short temper or seem incredibly agitated.
- Discuss a variety of topics quickly.
- Not feeling tired, but having trouble sleeping.
- Have trouble staying focused and experiencing rapid thinking.
- Take part in risky activities that you find pleasurable but not safe.
- Show poor judgment by taking risks or being reckless.
- Exaggerating their abilities affects a sense of superiority, knowledge, and power.

Children and teens having **depressive episodes** may[18]

- Unprovoked sadness occurs frequently.
- Become irritable, angry, or hostile.
- Pains like stomachaches and headaches are often complained about.
- Sleep more often.
- Concentration is difficult.
- The feeling of hopelessness and worthlessness is overwhelming.
- Relationships or communication are complicated.
- Overeat or undereat.
- They have no interest in their usual activities and have low energy levels.

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[15] 4 Types of Bipolar Disorder. Boston MindCare. 2020a. https://bostonmindcare.com/4-types-of-bipolar-disorder/.

[16] "Can You Have Both Bipolar Disorder and an Anxiety Disorder?" Accessed Mar 24, 2023. https://www.healthline.com/health/bipolar-and-anxiety.

[17] 4 Types of Bipolar Disorder. Boston MindCare. 2020a. https://bostonmindcare.com/4-types-of-bipolar-disorder/.

[18] Ibid.

- Suicidal thoughts or thoughts of death

Week 3: Bible Principles that Give Biblical Perspectives on Mental Health Part I

Compassion- Joses, also known as Barnabas

Compassion-focused therapy (CFT) is an evolutionary-based and biopsychosocial approach to treating mental health problems.[19] A significant source of the organization of psychophysiological processes that underlie mental health problems may be evolved motives (e.g., caring, cooperating, competing). Psychotherapy can therefore target evolved reasons. Certain types of depression tend to be psychophysiologically oriented toward social competition and social rank in people. These factors may result from the tendency to focus on lower-rank forms of social comparison, intolerance, worthlessness, a reduced sense of self-worth, the propensity to submit, shame, and self-criticism. In addition, individuals with Bipolar disorder have a higher level of competitiveness and higher evaluations of their status. Positive affect, energized behavior, and social dominance are the effects of these shifts in processing.[20] Love for those who are suffering is at the core of genuine compassion. The concept of compassion encompasses more than just being aware of someone else's suffering. The goal is more than just reducing suffering. A compassionate person recognizes others' suffering and helps.[21] In the Bible, there is an apostle named Joses, also known as Barnabas (Acts 4:36). Barnabas was a companion of the apostle Paul in the early years of his ministry.[22] According to the New Testament, Barnabas exhorted and encouraged other believers to remain faithful by demonstrating God's grace. The nickname "Son of Encouragement" comes from his desire to serve others.[23] Compassion in scripture motivates us to act.[24] Ministry leaders can be kind to one another and tenderhearted to these adolescents and young adults with special needs within their ministry (Eph 4:32).

Spiritual Support- Jesus, Garden of Gethsemane.

Psychosocial health experts have recognized religion as a relevant psychological factor. According to recent studies, higher levels of religious commitment associates with better

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[19] Gilbert, Paul, Jaskaran K. Basran, Joanne Raven, Hannah Gilbert, Nicola Petrocchi, Simone Cheli, Andrew Rayner, et al. "Compassion Focused Group Therapy for People with a Diagnosis of Bipolar Affective Disorder: A Feasibility Study." Frontiers in Psychology 13, (-7-20, 2022): 841932. doi:10.3389/fpsyg.2022.841932. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9347420/.

[20] Ibid.

[21] "Having Compassion and Being Moved to Action." Accessed Apr 5, 2023. https://www.compassion.com/about/what-is-compassion.htm.

[22] Aaron K. Tresham, "Barnabas the Apostle," ed. John D. Barry et al., *The Lexham Bible Dictionary* (Bellingham, WA: Lexham Press, 2016).

[23] "Having Compassion and Being Moved to Action." Accessed Apr 5, 2023. https://www.compassion.com/about/what-is-compassion.htm.

[24] Ibid.

physical and mental health and lower depression, suicide, and substance misuse rates.[25] Religious practices, such as prayer and meditation, spiritual direction, and idioms to express stress may act as mechanisms to explain the impact of religion on health, although further studies are needed.[26] A positive religious coping strategy involves intimacy with God, seeking meaning from sorrow, controlling feelings, staying spiritually comfortable, and having support from the religious community. Jesus wanted to be alone as He prayed in the Garden of Gethsemane (Matthew 26:36). However, when Jesus was going through a mini-depression breakdown, He took Peter and the two sons of Zebedee with Him. He began to be sorrowful and troubled (Matthew 26:37). The research found that positive religious coping strategies decreased depression symptoms in our population, suggesting their relevance to depression coping.[27]Often, when adolescents and young adults with bipolar disorder have a mental crisis, there is a particular need. There is not much need to have many people near or surrounding them during the crisis. To demonstrate support, ministry leaders can provide these individuals a separate room for personalized attention.

Week 4: Bible Principles that Give Biblical Perspectives on Mental Health Part II

Peace- Jesus, Amid a Storm.

In the church setting, research-informed mental health apps complement traditional treatment and promote mental wellness, and some may be useful for ministry leaders as a tool. The iBreathe app recommends for people looking for a simple way to promote calm, while MindShift is for people looking to relieve anxiety. It uses scientifically proven strategies rooted in CBT practices that encourage mindfulness and relaxation. Research indicates that deep breathing may help reduce stress.[28] Ministry leaders managing adolescents and young adults with special needs may feel their weak faith contrasts with the centurion's great faith because of inexperienced training.[29] However, according to biblical writings, a peaceful life comes from aligning with God's creative and redemptive purposes. Relationships between people are friendly, as are ethnic and political ones. The concept of peace has a cosmic meaning, as all aspects of creation ought to be harmonious. Ultimately, God's redemptive activity restores peace to design.[30] The Institute for Economics and Peace (IEP) defines negative peace as the absence or fear of violence. [31] The Gospel of Matthew contains two stories of Jesus' disciples

[25] Stroppa, André, and Alexander Moreira-Almeida. "Religiosity, Mood Symptoms, and Quality of Life in Bipolar Disorder." Bipolar disorders. 15, no. 4 (2013): 385–393.

[26] Ibid.

[27] Ibid.

[28] "Top 9 Mental Health Apps in 2022 Supported by Science," accessed Apr 5, 2023. https://psychcentral.com/health/evidence-based-mental-health-apps.

[29] John D. Barry et al., *Faithlife Study Bible* (Bellingham, WA: Lexham Press, 2012, 2016), Matt 8:26.

[30] Jonathon Lookadoo, "Peace," ed. Douglas Mangum et al., *Lexham Theological Wordbook*, Lexham Bible Reference Series (Bellingham, WA: Lexham Press, 2014).

[31] Vision of Humanity. "Defining the Concept of Peace." Accessed Apr 5, 2023. https://www.visionofhumanity.org/defining-the-concept-of-peace/.

experiencing a storm (Matthew 8:23-7, Matthew 14: 22-35), contrasting peace versus fear. Not having peace can negatively impact the ministry when managing individuals with bipolar mental disorder issues. “When in trouble, they turned to the Lord God of Israel and sought Him. They found Him,” as the prophet told King Asa centuries ago. He offered an encouraging assurance in response: “Do not let your hands be weak, for your work will be rewarded!” (2 Chronicles 15:4, 7). Ministry leaders can use the online tools suggested here to engage young individuals with bipolar disorder adolescents and young adults’ individuals in the ministry setting because the use of technology is currently in the church.

Leadership- Gideon, a call to lead and communicate.

A leader’s ability to motivate and inspire others is crucial to bringing about change and achieving results in the corporate world.[32]According to scripture, it is a biblical principle that leadership consists of servanthood (Mark 10:42-45). However, the Bible also teaches that legitimate leaders have authority, meaning they have the right to direct others. God delegated this authority to ministry leaders for the church’s benefit.[33] The world can sometimes seem hostile to people who have bipolar disorder. The assurance that you are on their side can help stabilize bipolar individuals. A minister leader does not have to agree with an individual’s actions and behaviors; reassuring them that you have their back constantly is very helpful.[34] Ministry leaders must lead and direct the affairs of the Church of God following Jesus Christ’s example.[35] Gideon’s fear, weakness, and insecurity about receiving his call to action by an angel is an example of special needs in the Bible.[36] It is common for ministry leaders to feel discouraged, distracted, and defeated.

Some might even think God chose the wrong person for the position.[37] Ministry leaders must have a straightforward guide on managing adolescents and young adults with bipolar disorder. These ethical guidelines are in the Bible and seen in the person and work of Jesus Christ (Matthew 20:25). The effectiveness of a ministry leader’s communication skills determines their ability to inspire, empower, and guide those around them; without them, no one

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[32] Maccoby, Michael. “Why People Follow the Leader: The Power of Transference.” Harvard Business Review (-09-01T04:00:00Z, 2004). https://hbr.org/2004/09/why-people-follow-the-leader-the-power-of-transference.

[33] “Leadership and Authority in the Church | Dwell Community Church.” (h). https://dwellcc.org/learning/essays/leadership-and-authority-church.

[34] “How to Help Someone with Bipolar Disorder.” Accessed Apr 6, 2023. https://www.healthline.com/health/bipolar-disorder/caregiver-support.

[35] Craig A. Smith, “Church Leadership,” ed. Douglas Mangum et al., Lexham Theological Wordbook, Lexham Bible Reference Series (Bellingham, WA: Lexham Press, 2014).

[36] Paul J. Achtemeier, Harper & Row and Society of Biblical Literature, *Harper’s Bible Dictionary* (San Francisco: Harper & Row, 1985), 347.

[37] Peters, Chuck. “5 Leadership Lessons from Gideon.” Accessed Apr 6, 2023. https://voices.lifeway.com/church-ministry-leadership/5-leadership-lessons-from-gideon/.

would hear them.[38] When the battle came, Gideon gave each of his 300 men their torches, trumpets, and clay pots and instructed them in Judges 7:17: "Watch me," he said to them, "and do what I do," and at this moment, Gideon gave us a vivid picture of biblical leadership.[39] Ministry leaders can inform these individuals that they want to connect with them to hear their thoughts.[40] By repeating what they heard, the ministry leader shows the individual they understand their feelings. When communicating and leading, asking questions, making eye contact, and nodding to indicate interest is essential.[41] To effectively manage bipolar individuals' unique needs in church settings, every ministry leader should be able to use this non-technical skill.

Week 5: Bible Principles that Give Biblical Perspectives on Special Needs Part III

Empathy- Jesus Extends Empathy, Kindness, and Care to those with Special Needs.

Sympathy, compassion, and tenderness are common feelings associated with empathy, and "self-awareness" is a crucial component of helping behavior.[42] People with Bipolar disorder have extreme mood, energy, and thinking swings. Empathy is not an official symptom of bipolar disorder. However, some research suggests it may also affect emotional skills, such as recognizing and understanding another person's feelings. Researchers believe this brain disorder may impact how well they can tune into and share others' emotions. Few studies are small, and their findings disagree. Still, researchers have theories about how bipolar disorder can alter their empathy.[43] In Luke 13:10-17, Jesus displays empathy by healing the disabled woman in defiance of religious law. Even though He was not crippled, He could relate to her infirmity. He wanted to be free of the woman's pain in physical and spiritual terms. It is also possible to experience empathy through distress or sadness for the person, distinct from direct despair or hopelessness caused by witnessing the person's suffering.[44] The idea that empathy is integral to what motivates people to help has been suggested by several researchers (e.g., Batson, 1987, 1991; Dovidio, Allen & Schroeder, 1990; Eisenberg & Miller, 1987). Batson et al.'s (1991, 1998)

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[38] Jaiswal, Sarvesh. Communication Skills for Effective Leadership | Emeritus India. Emeritus - Online Certificate Courses | Diploma Programs. 2022. https://emeritus.org/in/learn/why-are-communication-skills-necessary-for-good-leadership/.

[39] Jaiswal, Sarvesh. Communication Skills for Effective Leadership | Emeritus India. Emeritus - Online Certificate Courses | Diploma Programs. 2022. https://emeritus.org/in/learn/why-are-communication-skills-necessary-for-good-leadership/.

[40] Delzell, Emily. "What to Know About Bipolar Disorder and Empathy." . Accessed Apr 7, 2023. https://www.webmd.com/bipolar-disorder/bipolar-disorder-empathy.

[41] Ibid.

[42] Angela M. Sabates, Social Psychology in Christian Perspective: Exploring the Human Condition (Westmont, IL: IVP Academic, 2012).

[43] "3 Ways We See Jesus Display Empathy." Accessed Apr 7, 2023. https://www.ibelieve.com/relationships/3-ways-we-see-jesus-display-empathy.html.

[44] Sabates, *Social Psychology in Christian Perspective* (Westmont, IL: IVP Academic, 2012), 400.

empathy-altruism hypothesis propose that empathic concern produces altruistic motivation.[45] Jesus extended empathy to the woman, healing her with compassion and love even though He was not crippled as the woman was.[46] As well as being compassionate and empathic toward adults, Jesus was also understanding and empathic toward children.

Ministry leaders should listen to and empathize more with these adolescents and young adults, and learning empathy may benefit their ministry.[47] Children and women were both treated with compassion by Jesus, despite society's perception.[48] Matthew 19:14 states the kingdom of heaven belongs to such as these, so do not hinder the little children from coming to me. Research suggests that most of Jesus' children were ill, malnourished, or had deformities, which made them not considered elite members of society ("Compassion in the Life of Jesus," Our Daily Bread, 2021).[49] Empathy allows ministry leaders to show kindness, care, and compassion no matter the circumstance, and they can apply these examples to adolescents and young adults with bipolar disorder. [50]

Motivation- Jesus heals the paralytic.

In the same way that most other mental illnesses significantly impact your motivation, bipolar disorder also does. Depressive and manic episodes both reduce incentive, although in different ways.[51] Exercise can boost your motivation regardless of your mood. [52] The life expectancy of people with any mental health condition reduces by 7–10 years. [53] Bipolar mental health disorder has a life expectancy of 67.[54] Approximately 8-12 years less life expectancy in

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[45] Sabates, *Social Psychology in Christian Perspective.*

[46] "3 Ways We See Jesus Display Empathy." Accessed Apr 7, 2023. https://www.ibelieve.com/relationships/3-ways-we-see-jesus-display-empathy.html.

[47] Delzell, Emily. "What to Know About Bipolar Disorder and Empathy." . Accessed Apr 7, 2023. https://www.webmd.com/bipolar-disorder/bipolar-disorder-empathy.

[48] Ibid.

[49] Ibid.

[50] "3 Ways We See Jesus Display Empathy." Accessed Apr 7, 2023. https://www.ibelieve.com/relationships/3-ways-we-see-jesus-display-empathy.html.

[51] "Bipolar Disorder and Low Motivation: Causes and Coping Tips." Accessed Apr 7, 2023. https://psychcentral.com/bipolar/i-dont-want-to-motivation-bipolar-disorder.

[52] Wessa, Michèle, Julia Linke, Michèle Wessa, and Julia Linke. Emotional and Motivational Processes in Bipolar Disorder: A Neural Network Perspective IntechOpen, 2013. doi:10.5772/51890. https://www.intechopen.com/chapters/44829.

[53] Momen, Natalie C., Oleguer Plana-Ripoll, Esben Agerbo, Maria K. Christensen, Kim Moesgaard Iburg, Thomas Munk Laursen, Preben B. Mortensen, et al. "Mortality Associated with Mental Disorders and Comorbid General Medical Conditions." Archives of General Psychiatry 79, no. 5 (May 1, 2022): 444-453. doi:10.1001/jamapsychiatry.2022.0347. http://dx.doi.org/10.1001/jamapsychiatry.2022.0347.

the general population with bipolar disorder, and the age of diagnosis affects life expectancy by 2.6 times, based on a study from 2021.[55] Ministry leaders can implement any time of movement to help these individuals, such as five to ten minutes of yoga, basketball, volleyball, soccer, four-squares, or line dancing. Exercise has mental health benefits, and it can release endorphins to help youth and young adult bipolar individuals to feel more energized about accomplishing tasks.[56] Jesus healed a paralytic who had been invalid for 38 years. Jesus motivated this man to get up by acknowledging his need, asking him a question, and then commanding him to get up. (John 5:3-6). Many adolescents and young adults with bipolar disorder may feel like the paralytic man, "Sir," "I have no one to help me into the pool when the water is stirred. While I am trying to get in, someone else goes down ahead of me." (John 5:3-7). It calls for ministry leaders to encourage, motivate, and inspire these individuals. Leaders must develop this self-motivation before inspiring others, which requires reordering their priorities and discovering their potential. If the leader is not motivated, neither will the church be.[57]

Week 6: Symptoms of Sensory Overload, Leadership Alert, and Self-Care Measures

Symptoms of Sensory Overload

Touch, sight, hearing, smell, and taste are sensory overloads. They overstimulate one or more of the body's five senses.[58] They may have difficulties blocking unnecessary sensory information and gating out sensory input. There is a high sensitivity to noise in people with bipolar disorder. Even though no research is available on this, their brains may differ. Sensory overload can be very stressful.[59] When sensory overload occurs, it is essential to develop an exit strategy. In any situation where someone feels overwhelmed, talk with them about ways to remain calm or change their surroundings. To help with the sensory overload, take them outside,

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[54] Chan, Joe Kwun Nam, CoCo Ho Yi Tong, Corine Sau Man Wong, Eric Yu Hai Chen, and Wing Chung Chang. "Life Expectancy and Years of Potential Life Lost in Bipolar Disorder: Systematic Review and Meta-analysis." The British Journal of Psychiatry 221, no. 3 (2022): 567-76. doi:10.1192/bjp.2022.19.

[55] Chan, J. K. N., C. S. M. Wong, N. C. L. Yung, E. Y. H. Chen, and W. C. Chang. "Excess MLortality and Life-Years Lost in People with Bipolar Disorder: An 11-Year Population-Based Cohort Study." Epidemiology and Psychiatric Sciences 30, (May 28, 2021): e39. doi:10.1017/S2045796021000305. https://dx.doi.org/10.1017/S2045796021000305.

[56] Wessa, Michèle, Julia Linke, Michèle Wessa, and Julia Linke. Emotional and Motivational Processes in Bipolar Disorder: A Neural Network Perspective IntechOpen, 2013. doi:10.5772/51890. https://www.intechopen.com/chapters/44829.

[57] "Motivational Leadership." Accessed Apr 7, 2023. https://www.ministrymagazine.org/archive/1998/10/motivational-leadership.

[58] "Sensory Overload: Symptoms, Causes, and Treatment." Accessed Mar 27, 2023. https://www.medicalnewstoday.com/articles/sensory-overload.

[59] "Getting a Handle on Stress When You Have Bipolar Disorder, Part 2: The Connection between Stress and Bipolar Disorder - International Bipolar Foundation." Accessed Mar 27, 2023. https://ibpf.org/getting-a-handle-on-stress-when-you-have-bipolar-disorder-part-2-the-connection-between-stress-and-bipolar-disorder/.

retreat to a quiet room, remove them from the distraction, or give them a sensory toy in the event of an occurrence. These are some ideas to consider.[60]

Leadership Alert Measures

Even though individuals who have bipolar disorder are often gifted, they still need patience and new approaches to learn and grow. [61] These eight teaching strategies will help these students succeed:

Flexibility works best.

- Ministry leaders should adopt a more flexible lesson plan for individuals with bipolar disorder. [62]

Consistent schedules.

- The ministry leader should maintain focus and remain optimistic; bipolar individuals must incorporate many breaks during the day into their schedules when it is essential, however, that this routine stays consistent in the ministry setting. [63]

Few distractions.

- Ministry leaders need to be aware of distractions as they can cause more disruptive behaviors and can negatively affect the individual ability to focus. Some individuals must be seated near the front of the room to help reduce distractions. [64]

Practice patience.

- Ministry leaders must tolerate minor problems and recognize and praise positive behavior instead of focusing on adverse conduct. [65]

Maintain good communication.

- Ministry leaders should have open lines between educators, the school, and the child's parents/guardians because practicing good communication is essential, as adjusting as needed and attempting different approaches if something is not working. [66]

Have a plan.

- The ministry's leaders must be vigilant regarding signs of suicidal thoughts or extreme behavioral changes. Ministry leaders should have a plan for responding to these signs and

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[60] Digital, Power. "Sensory Overload: Tips for Helping Sensory Sensitive Children." Accessed Apr 7, 2023. https://www.ivyrehab.com/news/sensory-overload-tips-for-helping-sensory-sensitive-kids/.

[61] Magazine, bp. 8 Things Every Teacher Should Know About Bipolar Disorder. bpHope.Com. 2016. https://www.bphope.com/kids-children-teens/8-things-every-teacher-should-know-about-bipolar-disorder/.

[62] Magazine, bp. 8 Things Every Teacher Should Know About Bipolar Disorder. bpHope.Com. 2016. https://www.bphope.com/kids-children-teens/8-things-every-teacher-should-know-about-bipolar-disorder/.

[63] Ibid.

[64] Ibid.

[65] Ibid.

[66] Magazine, bp. 8 Things Every Teacher Should Know About Bipolar Disorder.

take them seriously. Parents, guardians, caregivers, and ministry leaders can decide on the method.[67]

Accommodate special needs.

- The ministry leaders should ensure that adolescents and young adults with bipolar disorders have unlimited restroom access and a water bottle.[68]

Agree on a safe place/person.

- Due to their inability to handle their emotions, individuals with bipolar disorder may feel overwhelmed, anxious, or out of control, so establishing a safe place and someone to go to in crisis is imperative for ministry leaders.[69]
- Ministry leaders should allow them to access to leave the room on their own.[70]

Leaders Self Aid Coping Care Skills

Spiritual Self-Care[71]

- Take time to reflect, meditate, and pray
- Time spent with God's creation (nature, children, the beauty of the world)
- Keep yourself accountable with the help of a friend, spiritual director, or community.

Physical Self-Care[72]

- Do not be afraid to take a break.
- Get massages, stretch, or do yoga to relax your body.
- Dance, swim, walk, run, play sports, sing, or do other fun physical activities.

Psychological Self-Care[73]

- Journal your thoughts.
- Consider your feelings, thoughts, judgments, beliefs, attitudes, and judgments.
- It is okay to say no to extra responsibilities from time to time.

Socio-Emotional Self-Care[74]

- Finding comforting activities, objects, relationships, and places is essential.
- Embrace your tears.
- Keep a list of things that make you laugh.

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[67] Magazine, bp. 8 Things Every Teacher Should Know About Bipolar Disorder.

[68] Ibid.

[69] Ibid.

[70] Magazine, bp. 8 Things Every Teacher Should Know About Bipolar Disorder. bpHope.Com. 2016. https://www.bphope.com/kids-children-teens/8-things-every-teacher-should-know-about-bipolar-disorder/.

[71] Grand Rapids Theological Seminary of Cornerstone University. "Resilience: Finding Wholeness in Ministry by Way of the Cross." (2020). https://www.cornerstone.edu/wp-content/uploads/2021/01/GRTS-Talking-Points-Self-Care-in-Ministry-Facilitator-Guide.pdf.

[72] Ibid.

[73] Ibid.

[74] Grand Rapids Theological Seminary of Cornerstone University. "Resilience: Finding Wholeness in Ministry by Way of the Cross." (2020). https://www.cornerstone.edu/wp-content/uploads/2021/01/GRTS-Talking-Points-Self-Care-in-Ministry-Facilitator-Guide.pdf.

Workplace or Professional Self-Care[75]

- Engage in exciting and rewarding projects and tasks.
- When ministering to others, set limits.
- Maintain a balance between workload and leisure.

Week 7: Educational Program Impact of Ministry Leaders Ministry

- **The University of Colorado Anschutz Medical Campus** has implemented its Colorado Bipolar Education (CoBE) Project under the Psychiatry School of Medicine department. Their bipolar disorder education is the heart of CoBE's mission to help patients, their families, and healthcare providers. As part of their mission, they disseminate knowledge and educate about the fundamentals and complexities of bipolar disorder based on the most effective and evidence-based treatments. The educational program consists of an 11-part video series, resources, self-assessment tools, mood charting apps, podcasts, and resources for caregivers with a find a therapist section. They also provide books, flyers, and brochures in their educational program.[76]

- **Saddleback, The Hope for Mental Health Ministry.** Pastor Rick and Kay Warren's youngest son's suicide after a lifelong struggle with mental illness. Saddleback Church united with Pastor Rick, his wife, and the community to provide holistic support to people who have mental illness and their families, which led to the establishment of the Hope for Mental Health Ministry. Each month, they hold services on the fourth Sunday. To help churches host their gatherings, they include videos of previous Mental Health Community videos and downloads. The site offers a treatment locator statewide and personal testimonies from community members. Additionally, Saddleback offers Christ-centered support groups where people learn to trust God's control and power while struggling for wholeness. As a final step, they offer churches resources and a mental health ministry starter kit to help them establish mental health ministries in their congregations.[77]

Week 8:Wrap-up session

- Post-Test Survey Questions
- Interview Questions
- Focus Group Questions

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[75] Grand Rapids Theological Seminary of Cornerstone University. "Resilience: Finding Wholeness in Ministry by Way of the Cross.".

[76] "Patients & Families." Accessed Apr 7, 2023. https://medschool.cuanschutz.edu/psychiatry/colorado-bipolar-education-project/patients-families.

[77] "Hope for Mental Health." Accessed Apr 7, 2023. https://hope4mentalhealth.com/.

NAMI SC Resources

Midlands Mental Health Resource Guide: RESOURCE GUIDE (namisc.org)

Free, 24/7, Confidential Crisis Support Text Line: Flyers and Stickers.pdf (namisc.org)

Online Resources for Families: Resource-List-for-Families.pdf (namisc.org)

Common Warning Signs of Mental Health: NAMI_WarningSigns (namisc.org)

Student Resource Flyer: NAMI-SC-ETS-Student-Resources-Flyer-1.pdf (namisc.org)

SC Resources Flyer: With Students in Mind Mental Health Resources Flyer (namisc.org)

SC Community Crisis Response & Intervention: programinfo (namisc.org)

SC Local and National Resources: Local and National Resources - NAMI South Carolina (namisc.org)

Free Educational Program (parents, family caregivers, significant others, friends of people living with mental illness, and peer-to-peer for adults with mental illness) Mental Health Education - NAMI South Carolina (namisc.org)

Essential Information and Resources: Teens and Young Adults - NAMI South Carolina (namisc.org)

NAMI Family Support Groups are free, confidential and safe groups of families helping other families who live with mental health challenges by utilizing their collective lived experiences and learned group wisdom.): Find Your Local NAMI | NAMI: National Alliance on Mental Illness

IRB Approval Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

April 19, 2023

La'Shanna Williams
David Barnett

Re: IRB Application - IRB-FY22-23-1413 Assisting Ministry Leaders Managing Bipolar Disorder in Adolescents and Young Adults

Dear La'Shanna Williams and David Barnett,

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

Decision: No Human Subjects Research

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

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

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

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

Sincerely,

G. Michele Baker, PhD, CIP
Administrative Chair
Research Ethics Office