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The Effects of Mental Illness on Families within Faith Communities

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Abstract

The present study examined the experiences and values of families caring for a mentally ill loved one within the context of a Christian faith community. Participants (n = 5,899) in 24 churches representing four Protestant denominations completed a survey describing their family's stresses, strengths, faith practices and desires for assistance from the congregation. Results showed mental illness in 27% of families, with those families reporting twice as many stressors on average. In addition, families with mental illness scored lower on measures of family strength and faith practices. Analysis of desires for assistance found that help with mental illness was a priority for those families affected by it, but ignored by others in the congregation. These results suggest that mental illness is not only prevalent in church communities, but is accompanied by significant distress that often goes unnoticed. Partnerships between mental health providers and congregations may help to raise awareness in the church community and simultaneously offer assistance to struggling families.

The Effects of Mental Illness on Families within Faith Communities

It is well understood that families are negatively affected when a member has a mental illness. The specific effects of mental illness on families have been studied extensively, with particular attention given to the burdens of care giving. As a result of deinstitutionalization, more seriously mentally ill patients are being sent home after short hospital stays, and families bear much of the burden for their care. Research on caregivers of persons with mental illness often examines both objective (e.g. time demands) and subjective or affective (e.g. feeling overwhelmed) burdens (Thompson & Doll, 1982). Studies have consistently shown that even families with few or no reported objective burdens often feel some level of subjective/affective burden. One reason for this may be the stigma surrounding mental illness. It has long been known that people tend to make more negative judgments about people identified as having a mental illness (Link, Cullen, Frank, & Wozniak, 1987; Socall & Holtgraves, 1992), and there is evidence from a recent longitudinal analysis that stigma related to mental illness remains high (Lyons, Hopley, & Horrocks, 2009). Families likely face not only the subjective burden of perceived stigma from outside the family, but also their own conflicting feelings toward the mentally ill member.

Objective burdens can be debilitating as well. The challenges of families dealing with mental illness are often compounded by financial difficulties. Not only is the family responsible for some of the costs of care for the ill member, but other members' health care costs increase as well (Gianfrancesco, Wang, & Yu, 2005). Families often have to deal with a loss of employment income when a significant earner is the ill member (Baker, Procter, & Gibbons, 2009; Bell & Lysaker, 1995; Kennedy & Schwab, 2002). Even if a job is not sacrificed, there are often other

work related complications. For example, mental illness has been correlated with increased work stress and higher levels of work and family life imbalance (Wang, 2006).

Parental depression has often been the subject of family-effects research, as scientists seek to understand the effects of parental illness on spouse and children. Foster et al. (2008) found that mothers with depression have impaired parenting skills, and their families suffer from increased dysfunction as the length of the illness increases. Mental illness in one spouse can lead to increased marital discord, decrease the well-being of the other spouse, and sometimes result in divorce (Burke, 2003; Cummings, Keller, & Davies, 2005; Marsh & Johnson, 1997). This heightened family conflict is not only an issue in its own right, but also has been identified as a mediational process for both internalizing and externalizing symptoms in the children of families with a depressed parent (Cummings et al., 2005; Keller, Cummings, Peterson, & Davies, 2009).

Families are at risk for dysfunction regardless of the particular psychiatric diagnosis. Friedmann et al. (1997) studied families of individuals with schizophrenia, bipolar disorder, major depression, anxiety disorder, eating disorder, substance abuse and adjustment disorder, measuring family functioning on seven dimensions. They concluded that "Regardless of the specific diagnosis, having a family member in the acute phase of a psychiatric disorder appears to be a risk factor for poor family functioning across many areas, including problem solving, communication, affect expression and responsiveness, role allocation, and general functioning." (p. 6). Research on Thai families with a member experiencing depression or schizophrenia also found a large majority of both groups had dysfunctional family relationships in similar areas of problem solving, communication, affective responsiveness, and affective involvement (Trangkasombat, 2008).

While these families are at risk for impaired function, many find a way to cope and adapt to the disorder in their midst. Family resilience has been defined as the ability to resist disruption in the face of change, and to adapt when faced with crisis (McCubbin & McCubbin, 1989). One study reported on findings in three separate areas of resilience: the overall family's resilience, each individual's resilience, and the resilience of the person with the mental illness (Marsh, Lefley, Evans-Rhodes, Ansell, & Doerzbacher, 1996). Participants describing their experiences referred to resilience factors such as family bonds and family growth, individual contributions and better perspectives, and the positive personal qualities and recovery process of the persons with mental illness. Jonker and Greef (2009) studied family resilience and found that 67.6% of respondents cited religion and spirituality as playing a role in helping their family care for a mentally ill member, making it one of the most frequently cited resilience factors. The authors concluded that interventions with families should include tapping the spiritual and religious internal resources of the family. This should be no surprise, given the large amount of research on the relationship between religiosity and mental health.

Effects of Religion and Spirituality

Religious involvement has been related to a host of positive health outcomes, including "better coping with stress and less depression, suicide, anxiety, and substance abuse" (Koenig, 2009, p. 289; see also Hackney & Sanders, 2003). A negative association between religiosity and depression has been found which becomes even stronger in the presence of acute stress (Smith, McCullough, & Poll, 2003). A study of depression in adolescents found that a loss of faith predicted less improvement in depression, and that religion had effects over and above the contributions of social support (Dew et al., 2010). Overall, religious activities and beliefs may

serve as powerful methods of coping with psychological disorder and distress, and may have particularly potent effects for those experiencing severe symptoms (Tepper, Rogers, Coleman, & Malony, 2001).

More than merely serving as a protective factor for mental illness, religious beliefs and practices are consistently linked to indicators of well being. Koenig, McCullough & Larson (2001) reported that out of 100 studies specifically addressing the relationship between religious involvement and aspects of well-being, only one found a negative correlation, while 79 reported a positive correlation. Similarly, numerous studies have shown an association between religiousness and many known predictors of well being, including marital status, health, hope, purpose in life and internal locus of control.

Studies with psychiatric inpatients and matched controls have found that the primary factor in patient expression of religious conflicts was their psychopathology, not their level of religious commitment (Pfeifer & Waelty, 1995, 1999). The patients themselves often claim that religion or spirituality played a key role in helping them cope with their symptoms (Fitchett, Burton, & Sivan, 1997; Kroll & Sheehan, 1989; Lindgren & Coursey, 1995). Furthermore, patients are often distressed by the effect that the mental illness has on their ability to practice and express their faith. The authors of one study concluded that "it is not primarily religion that causes illness, but it is illness that makes the practice of religion difficult" (Pfeifer & Waelty, 1999, p. 43). In the same vein, Hathaway (2003) argued that the mental health community needs to recognize this negative impact on individual religious functioning and include it in diagnostic criteria as a dimension of clinically significant impairment.

Congregations and Mental Illness

These findings on the effects of religious involvement and prevalence of religious coping bear particular weight because of the high percentage of the U. S. population that claims a religious affiliation. More than 80% of the US population claims membership in some religious community (Pew Forum on Religion & Public Life, 2008), and there are an estimated 670,000 clergy in the United States (U.S. Department of Labor, Bureau of Labor Statistics, n.d.). Religious congregations are often a place of comfort and healing for individuals. In fact, the role of the clergy as "gatekeepers" for treatment access has long been established: Clergy tend to be sought out first and at greater rates than mental health professionals by individuals concerned about their functioning (Wang, Berglund, & Kessler, 2003; Weaver, Flannelly, Flannelly, & Oppenheimer, 2003; Weaver, Flannelly, Larson, Stapleton, & Koenig, 2002). It follows that clergy and religious communities have a potentially large role to play in the lives of families with a mentally ill member.

However, a few problems exist: Congregations and clergy have not always been supportive in their dealings with issues of mental health, and there is little research on the interactions of congregations and families with a mentally ill member. Though evidence has been presented that many pastors increasingly do have an understanding of mental issues as biologically or environmentally influenced (Lafuze, Perkins, & Avirappattu, 2002; Stanford & Philpott, 2011), there are still indications that many do not recognize medical causes of disorder, or rate spiritual causes more highly than physiological or emotional causes (Payne, 2009). Even if they do profess mainstream views of etiology, many pastors are unable to recognize the symptoms of mental illness and have not been prepared to provide professional care for persons with mental illness (Farrell & Goebert, 2008; Moran & Wilson, 2005). In addition, if they have had clinical

pastoral education, they are still not in a role that provides the time and organizational context to offer clinical services to persons with mental illness (Justice & Garland, In Press).

Despite these limitations, many pastors hesitate to refer people for mental health services (Moran & Wilson, 2005). The majority of congregants who present to a clergy member with a serious mental illness thus only receive care from the congregational leader and not from a medical or mental health professional (Wang et al., 2003). For example, Baptist pastors reported using referral as an intervention in only 40% of the situations in which they were presented with mental illness (Stanford & Philpott, 2011). Moreover, recent evidence indicates that although many individuals experience support in their faith communities, a significant number of individuals have been alienated from their congregations as a result of interactions concerning their disorder (Stanford, 2007). Twenty-six percent of the respondents in Stanford's study (2007) stated that their problem seemed worse as the result of the congregation's involvement, while 27% said that their faith was either weakened or lost altogether as a result of the interaction.

As summarized above, good research exists on the family burden of mental illness, the benefits of religious involvement, and effects of religious and spiritual coping. There is little or no research on families with a mentally ill member in the context of their faith community, however. A search of PsycINFO abstracts from the last 20 years was performed using the criteria "Family AND (function* OR disorder OR "mental illness") AND (church OR congregation)." The 55 results contained several articles examining religiosity or the effects of church involvement, but none reported the experiences, characteristics or functioning of families in a church community as they related to the mental illness of a family member.

This gap in the research literature leaves several important questions unanswered: How does mental illness of a family member affect the family's connection with the religious community? Do congregations know about these families in their midst and if so, are they responding to their needs? Are these families looking for assistance from the congregation? How might professionals encourage the development of a supportive relationship between families and their faith communities? The current study provides initial data in an attempt to answer these questions and spark further research and discussion.

Methods

Participants

Participants were 5,899 adults (18 years of age and older) that completed the Church Census (Garland & Yankeelov, 1998, 2001; Yankeelov & Garland, 1998, 2004). The sample was gathered between 2008 and 2010 and represented 24 Protestant Christian congregations in 10 states. The 24 congregations were affiliated with the following denominational identities: Baptists (including Cooperative Baptists, Southern Baptists, National Baptists and Missionary Baptists), *n*=14; Church of Christ, *n*=7; nondenominational, *n*=2; and Lutheran [ELCA], *n*=1). Demographic information for the total sample is presented in TABLE 1.

Church Census

The CC is an 11 page self-report instrument that identifies the demographic characteristics of congregation families, the stresses they experience, what makes them strong, how they practice their faith, and what they say they want from their congregations to help their family and other families. The Center for Family and Community Ministries (CFCM), a research and service unit

of the School of Social Work at Baylor University, offers the CC to congregations as a paid congregational assessment service.

Congregation leaders are asked to conduct the CC during a time when most of the attendees are gathered, often during or immediately following weekly gatherings for worship. Surveys are completed anonymously. Congregation leaders then mail the completed surveys to the CFCM. There the surveys are computer scanned and analyzed. The completed analysis is used by the CFCM to produce a detailed report that is sent to the congregation leaders to serve as a foundation for family ministry planning.

In addition to questions related to the information listed above, the CC also contains two psychometrically developed scales. The *Family Strengths Scale* (Garland & Edmonds, 2007; Garland & Yankeelov, 1998) is a 15 item measure that assesses categories of family strength. These include family cohesion (e.g., "we can depend on each other."), conflictual communications (e.g., "when we are angry, we talk it out rather than yelling, grabbing, slapping, hitting, or throwing things at one another"), adaptability and flexibility (e.g., "we compromise when we need to"), companionship (e.g., "our family spends time together with friends or neighbors"), and community connections (e.g., "we seek help when we need it from outside the family"). Items are scored on a 5-point Likert scale (Never, Not Often, Sometimes, Often, and Always) with higher scores representing greater family strength.

The *Christian Faith Practices Scales* (Sherr, Stamey, & Garland, 2009) is a 10 item self-report measure that assesses three areas related to faith behaviors. These include devotional practices (e.g. "attend weekly worship services"), relating (e.g., "confess my faults to others") and serving (e.g., volunteer to help those less fortunate"). Items are scored on a 7-point Likert

scale (Never, Rarely, Once in a While, Sometimes, Often, Almost Always, and Always) with higher scores representing greater involvement in faith related behaviors.

Group Assignment

Assignment to groups was based on whether the participant identified that depression or other serious emotional problems caused stress within the last year for their family. Participants who had dealt with such stress were placed in the Depression/Emotional Problems group (DEP; 27.1%, n = 1,600) while all others were grouped as Controls (CON; 72.9%, n = 4,299). Demographic information for the two groups is presented in TABLE 1.

Results

Demographics

Comparison of the demographic data found that individuals in the DEP group were younger ($t(5381) = 8.0$, $p < 0.001$), more likely to be female ($\chi^2(1) = 6.0$, $p = 0.01$), at their present church fewer years ($t(5897) = 5.0$, $p < 0.001$), and less likely to be married ($\chi^2(2) = 69.2$, $p < 0.01$) when compared to the CON group. No significant differences were found between the groups for the family's racial/ethnic identity, household income, highest level of education, or likelihood to have children in the home (TABLE 1).

Family Stress

The family stress section of the CC list 40 stressors grouped into five categories: physical and emotional health (e.g., "caring for a sick or disabled family member"); interpersonal relationships (e.g., "too much parent-child conflict"); work, school and other outside activities

(e.g., “problems balancing work and family”); home, community and neighborhood (e.g., “legal problems”); and money (e.g., “financial strain”). Participants were asked to mark all the items that created stress within the last year for their family. “Depression or other serious emotional problems” is listed in this section of the CC under physical and emotional health. Because this item was used to group the participants, it was not included in any of the family stress analyses.

Analysis of family stressors ($t(5897) = -33.2$, $p < 0.001$) showed that individuals in the DEP group ($M = 5.46$, $SD = 3.76$) identified significantly more family stressors in the last year than those in the CON group ($M = 2.66$, $SD = 2.47$). TABLE 2 lists the percentage of families who reported being affected by a given stressor in the last year. All stressors identified as affecting at least 20% of the DEP group were included, and the corresponding rates at which CON group families identified those same stressors are listed. Coincidentally, the two groups identified the same top five stressors. As can be seen from TABLE 2, every stressor listed was reported to affect a significantly higher percentage of families in the DEP group compared to those in the CON group.

Family Strengths and Faith Practices

A *t*-test was used to compare the two groups on the total scores of both the *Family Strengths Scale* and the *Christian Faith Practices Scale*. Analysis of the *Family Strengths Scale* found that the CON group scored significantly higher (CON: $M = 61.8$, $SD = 7.2$; DEP: $M = 58.2$, $SD = 8.2$; $t(4668) = 14.0$, $p < 0.001$) compared to the DEP group. The CON group also scored significantly higher than the DEP group on the total score (CON: $M = 64.1$, $SD = 11.9$; DEP: $M = 62.3$, $SD = 11.6$; $t(4834) = 4.9$, $p < 0.001$) of the *Christian Faith Practices Scale*.

Participants were also asked to report how often they prayed on a 7-point Likert scale (Never, Rarely, Once in a While, Sometimes, Often, Almost Always, and Always). Individuals in the DEP group reported praying significantly less often ($\chi^2(6) = 36.2$, $p < 0.01$) and were more likely to report that one or more of their family members did not attend church (DEP 13.3%, CON 6.8%; $\chi^2(1) = 60.9$, $p < 0.01$) compared to the CON group.

Ways the Church Can Help

One section of the CC asked participants to mark up to six items in a list of 47 to indicate issues with which they would like to see their church help their family and other families. TABLE 3 lists the six most commonly marked items for the DEP and CON groups.

Discussion

The results of the present study demonstrate that a high percentage of Christian congregants struggle with mental illness in their families. Consistent with a large literature on family burden and family functioning in the presence of mental illness, these families reported more stressors, more frequent financial trouble, and more conflict and crisis. These families also showed less involvement in faith practices, but would like their congregation to provide assistance with mental health issues. However, the rest of the church community seems to overlook their need entirely: help with depression and mental illness was the second priority of families with mental illness, while it ranked 42nd on the list of requests from control families. This difference in response is staggering, especially given the picture of distress painted by the data: families with mental illness reported twice as many stressors and tended to ask for assistance with more

immediate or crisis needs compared to other families. These data give the impression that mental illness, while prevalent, is also nearly invisible within the congregation.

While struggling families want help from the congregation, it seems that the rest of the faith community fails to recognize or understand their need. Indeed, current research has shown that pastors often lack the training to recognize mental illness, and many people who do bring their mental health struggles to the church have had their disorder dismissed (Farrell & Goebert, 2008; Moran & Wilson, 2005; Stanford 2007). In an atmosphere where mental disorders are viewed as spiritual problems, and hence need only spiritual intervention, families may be reluctant to talk about their struggles for fear of being judged.

Even when congregational beliefs about mental illness are less stigmatizing, pastoral staff presented with mental illness often fail to recognize the disorder or the need for additional help (Stanford & Philpott, 2011). The family then continues to struggle without having their problem effectively addressed. Even when congregational leaders recognize the need for help and make an appropriate professional referral, more is needed. Congregations have the opportunity to do something that professionals cannot; provide friendship and simple presence so that the family is less isolated by the illness. Congregations are adept at responding to crises such as physical illness, injury or death in families. They show up with meals, visit in hospitals, provide respite child care, and lend listening ears. But both leaders and congregants may have no experience in responding to the needs of families dealing with mental illness, not recognizing that the casserole, phone call, or "thinking of you" card can communicate much-welcomed concern and support. Instead, the congregation's silence intensifies feelings of isolation and even shame.

Compounding the problem, individuals with mental illness often report difficulty practicing their faith (Hathaway, 2003; Pfeifer & Waelty, 1995; 1999), and may withdraw from the church.

This separates them from a highly valuable support system (Tepper, et al., 2001) at the same time further reducing the visibility of their need to the faith community. At the very moment when they most need support in their faith, they may be least likely to seek help, and most vulnerable to problematic responses to their disorder. Families with mental illness stand to benefit from their involvement within a congregation, but current patterns suggest that faith communities fail to adequately engage these families because they lack awareness of the issues and understanding of the important ways that they can help.

Limitations

The current results were limited by a survey instrument not originally designed with mental illness in mind. Identification of mentally ill members was not rigorous, and scales such as the FSS and the CFPS were not designed to assess their respective factors relative to mental illness. Despite this, the results show small but significant differences between groups. A more comprehensive set of measures would likely yield more robust results. Sample characteristics are another limitation: the current results are based on a non-random convenience sample of responses from congregants in 24 churches from four denominations. Nevertheless, results indicating high levels of family stress, relational conflict and financial difficulties related to care giving of a mentally ill loved one are consistent with a large body of past research (Burke, 2003; Friedmann et al., 1997; Gianfrancesco et al., 2005; Lefley, 1989; Thompson & Doll, 1982).

Recommendations and Application

It is unfortunate that families who experience such distress, and who often actively desire help from their churches, may not receive the assistance or support they need. Mental health

professionals, church leadership, congregations and the families themselves all have important roles to play in addressing this situation by bringing to life a collaborative community response.

Mental health professionals can help church communities to understand the struggles of families dealing with mental illness and can facilitate the creation of a more adaptive response. In order to achieve this, they need to be proactive in building relationships with faith communities. These relationships provide a personal connection to the mental health community, and ease the process of making referrals. Reaching out to faith communities on behalf of current clients can be an effective, proactive method of building relationships. Congregational leaders are often more receptive to contact when they are dealing with a current situation, and clients may give permission to contact and talk with religious leaders in order to apprise them of ways the community can best be supportive. In turn, this experience will provide a pathway for future collaboration. As relationships are built and strengthened, mental health professionals can offer training to church leaders, increasing their ability to recognize and respond to disorders. Similarly, their knowledge of the issues facing families with a mental illness makes them a natural point of contact for congregations looking to respond to those members. However, congregations are more likely to tap the knowledge of a professional if that individual has already established a presence in the church, increasing the importance of being proactive in engaging with the faith community.

In their turn, religious leaders can better serve these families by building relationships with local mental health providers and learning what resources are available outside the congregation. As their knowledge and resource base expands, they can respond more effectively to those who seek their counsel. At the same time, they can help mental health providers understand religious beliefs, values, and practices that can be resources for clients and their families. Religious

leaders can also assist by educating their congregations – and being educated by them. They can learn from those in their midst what it means to struggle well with mental illness, and by interacting with them, understand better how to support them. Through teaching and by personal example, they can help their congregations understand that mental illness is a real problem in their midst. Given the need reported by families struggling with mental illness, pastors can help their congregations to see the congruence between their call to spiritual service and ministry to families with a mentally ill loved one.

Congregations themselves are not particularly responsive to community needs unless they have personal experience with those needs that elicits not only concern but an understanding of how they can respond (Garland, 2008; 2010). One fruitful approach to engaging congregations with families struggling with mental illness is to encourage congregants who have lived through similar experiences to tell their stories including how a congregation helped – or could have. These individuals exist in faith communities; they are adults who grew up in a home with a mentally ill parent; they are persons who themselves are dealing with mental illness or have in the past. Indeed, data from the current study indicate a large percentage of current congregants are a part of families coping with mental illness. A personal testimony by those who have suffered has double benefit; we find meaning and purpose in our struggles if we can use them on behalf of others. At the same time, congregations learn that they do not have to be mental health experts to provide community support to families in crisis.

As their awareness of the issue increases, congregations can follow their call to service by keeping families coping with mental illness engaged in the life of the congregation, caring for others as well as being cared for. There is no poverty deeper than having nothing to give others. Calling persons with mental illness and their families to share their own gifts in service, however

they are able, may provide meaning and hope during a time when their challenges may otherwise seem overwhelming. Congregations can also do something that professionals cannot; provide the friendship and simple presence that helps to inoculate these struggling families from the illness of isolation. This ability to provide a personal response in the context of existing relationships is a particular strength of faith communities that is often tapped to support congregants with a variety of other needs. As mentioned before, those casseroles, phone calls and cards can also benefit families coping with mental illness by providing a relationship that connects them to the faith community and proves that they are cared for and supported. In these ways, congregations can not only learn how to recognize those families who need help, but actively seek ways to keep them connected to the faith community, and offer tangible support and friendship.

Conclusions

This study serves to extend the literature on families with mental illness by examining families in the context of their faith communities. A majority of these families want their church to assist them in dealing with mental illness, but unaffected families and clergy seem oblivious to the problem in their midst. While churches endorse a mission of service to those in need, they appear to be missing this growing issue within their own congregations. Mental health professionals can help by reaching out to form connections with faith communities. They can collaborate to provide education about the prevalence, symptoms and effects of mental illness, as well as being referral resources. Likewise, pastors can help set a vision for their congregations that includes a mission of service to their own members who may be coping with mental illness. With increased awareness, suffering families can be better supported by individual congregants, connected more efficiently to professional help, and encouraged to stay engaged with the

community in meaningful ways. In this way, a collaborative stance between mental health professionals and congregations leads to better connection with both the faith community and mental health system, maximizing the supports for families struggling with mental illness.

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TABLE 1
Demographics for the Total Sample and Comparison Groups

Measure	Total Sample (n = 5,899)	Depression / Emotional Problems (n = 1,600)	Controls (n = 4,299)
Age (Years)	52.5 (16.4)	49.6 (14.9)	53.6 (16.9)
Years at Present Church	14.6 (14.4)	13.0 (13.0)	15.1 (14.8)
Gender			
Female	51.1%	54.5%	49.8%
NR	11.2%	9.5%	11.9%
Marital Status			
Married	83.1%	75.6%	85.9%
Single	7.4%	10.5%	6.2%
Divorced / Separated	7.1%	11.4%	5.6%
NR	2.4%	2.5%	2.3%
Children in the Home			
Yes	75.3%	75.6%	75.2%
Family's Racial/Ethnic Identity[a]			
Caucasian	88.7%	89.4%	88.4%
African-American	7.1%	8.3%	6.7%
Native American	2.4%	2.6%	2.4%
Hispanic	1.6%	1.6%	1.6%
Asian	0.9%	0.8%	0.9%
NR	2.8%	1.8%	3.2%
Household Income			
< $30,000	10.8%	12.1%	10.3%
$30,000-59,999	21.1%	25.9%	19.2%
$60,000-89,999	20.7%	20.4%	20.8%
$90,000-119,999	15.9%	16.9%	15.6%
$120,000-149,999	7.8%	6.6%	8.3%
$150,000 or more	12.4%	11.0%	12.9%
IDK / NR	11.3%	7.1%	12.9%
Highest Level of Education			
8th Grade or less	0.4%	0.3%	0.4%
Some High School	1.0%	0.8%	1.0%
High School Graduate	11.0%	10.4%	11.2%
Vocational Training	3.6%	3.8%	3.5%
Some College	22.7%	25.0%	21.9%
College Graduate	32.5%	32.1%	32.7%
Graduate School	27.0%	26.6%	27.1%
NR	1.8%	1.0%	2.2%

Note. NR = No Response; IDK = I don't know our family income (this was a possible survey response for this item)
[a]Participants were allowed to mark all that applied to their family on the racial/ethnic identity item.

TABLE 2
Family Stress

Item	Depression / Emotional Problems (n = 1,600)	Controls (n = 4,299)	χ^2 (1)
Financial strain	49.6%	25.7%	304.2
Serious illness or disability of a family member, close friend or relative	42.5%	28.0%	112.7
Setting priorities for using money	42.5%	25.1%	168.2
Problems balancing work and family	30.8%	20.5%	69.1
Death of a family member, close friend or relative	28.5%	20.9%	37.7
Difficulty on the job for a family member	28.2%	15.8%	115.1
Caring for a sick or disabled family member	27.4%	17.9%	64.8
Too much other conflict or strain	22.8%	6.8%	299.1
Too much parent-child conflict	22.4%	8.2%	222.4

Note: All differences significant at $p < 0.001$.

TABLE 3
Group Comparison of Top Six Issues the Church Can Help Families With

Depression / Emotional Problems Group
Knowing what we can do together to make a difference for others
Depression, mental illness
Developing a strong marriage
Managing money
Handling conflict and anger
Coping with crises
Control Group
Knowing what we can do together to make a difference for others
Finding ways we can include all ages in community service
Developing a strong marriage
Retirement
Caring for sick, disabled, or aging family members
Managing money